UNINSURED AMERICANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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UNINSURED AMERICANS

TUESDAY, JUNE 15, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:05 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
June 8, 1999
No. HL–6

Thomas Announces Hearing on Uninsured Americans

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on those individuals without health insurance. The hearing will take place on Tuesday, June 15, 1999, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 11:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Health insurance coverage is among the most important contributors to Americans' personal and financial security. Nonetheless, despite the nation's strong and growing economy, today more Americans are uninsured than at any other time in modern history. The latest studies indicate that more than 43 million Americans have no health coverage whatsoever. And this number is growing. Not only are Americans without insurance exposed to the potential for catastrophic financial liabilities in the event of illness, lack of insurance often discourages individuals from seeking proper and timely treatments. The presence of such a large number of uninsured patients in the health care system has also created troubling distortions in the financing of care, resulting in inefficient cross-subsidies and delivery trends.

Several recent changes to law have been aimed at addressing the problem of the uninsured. In 1996, portability and guaranteed issue and renewability requirements were established for all health insurers in the Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104–91). The HIPAA law ensures that those who currently have insurance will be able to continue to gain access to coverage, even in the event of a job change or disabling illness. The legislation also included "medical savings accounts" (MSAs). Medical savings accounts combine less costly catastrophic health insurance coverage with tax-favored savings accounts that are dedicated to paying routine medical costs. In addition, these accounts offer individuals the ability to accumulate savings that can be used for specific needs, like long-term care, later in life.

Many other provisions in the tax code impact the financing of private health insurance. The current deductions for employer-provided health coverage and the individual exclusion, make employer-provided insurance a tax-free benefit for American workers. In addition, the tax code provides an individual deduction for health care costs in excess of 7.5 percent of one's adjusted gross income.

In announcing the hearing, Chairman Thomas stated: "Having access to affordable health insurance is clearly one of the most important patient protections of all. This hearing will help us better understand why, despite our many efforts to address the uninsured, the problem continues to persist."

FOCUS OF THE HEARING:

The hearing will seek the input of several academicians, employers, and policy experts in evaluating the characteristics of the uninsured, and in determining what factors are behind the continuing rise in the uninsured population, despite the country's continuing economic growth. The Committee will consider potential solutions to address the problem of the uninsured at a later hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, with their name, address, and hearing date noted on a label,* by the close of business, Tuesday, June 29, 1999 to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect 5.1 format, typed in single space and may not exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "http://www.house.gov/ways__means/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. The Subcommittee will come to order.

This morning's hearing I think is going to be useful to Members in a number of ways as we begin looking at not just health care packages, but tax packages as well, because the American health care system has demonstrated a unique capacity to deliver the highest quality medical care, but financing that care remains a real challenge. In recent years, the private sector is showing a remarkable ability to slow the growth and then, seminally, in 1997, at which time it was in fact the old-fashioned way of basically reducing providers, the Medicare growth was slowed as well.

Still, when you look out a few years, as all of us who are trying to deal with the issue do, look at the baby boom generation, not just from a Medicare point of view, but from technology driving health care costs, if not in the add-on of technological devices, then the molecular capability of designing new solutions through pharmaceuticals, notwithstanding the fact that some of them are enormously expensive.

Today the Subcommittee will examine the impact of rising costs on the problem of the uninsured. The problem of the uninsured is, I think, one of the clear evidences of the system being fundamentally flawed. Despite record low unemployment, there are a record number of Americans without health insurance. According to various estimates, and some of our witnesses will provide a better understanding of what some of these numbers mean and whether or not we can have a comfort level with them, but the normal number is 43 million Americans without health insurance.

The concern is that the ranks of the uninsured are growing, again, notwithstanding high employment. Of course, this fact has consequences for millions of Americans who face a financial catastrophe as well as health care concerns because I think you will see there is a clear relationship in terms of, to a certain degree, income, health, geography, and ethnic origin.

Much political debate in recent months has been devoted to the issue of patient protections. Of course, the irony of that is it is dealing with people who already have insurance and, in fact, some of the so-called solutions may compound the problem of the uninsured and we will hear some concerns about that as well. As a matter of fact, we have had some Congressional Budget Office testimony about increased regulation, notwithstanding how well-intentioned it might be, leading to higher costs, leading to more uninsured. And the question of regulation and the uninsured needs to be better understood before we move, in my opinion, additional legislation.

Of course, we are beginning to hear that on the horizon there are, notwithstanding efforts to control costs, the potential of increasing costs, which would be a clear pressure just on the cost factor alone, of increasing the number of uninsured. And for employers shifting additional costs over to employees means, notwithstanding the fact that the employer offers insurance, the employees choose not to avail themselves of it. Some interesting statistics from our panel in that area as well.

Today we are going to examine the problem of the uninsured. This panel—and I fully understand some of your reluctance to get in and talk about it because everybody's advocating a solution, and one of the things that I have found is that there are far more peo-

ple, in my opinion, advocating a solution than there are who really understand the interactions of some of those solutions. And so one of the things I would like to do is to, at least from the Health Subcommittee perspective, provide an understanding of what the world of the uninsured looks like so that when we begin to try to solve the problem, the solutions, in fact, address the problem.

[The opening statement follows:]

Opening Statement of Hon. Bill Thomas, a Representative in Congress from the State of California

The American health care system has demonstrated a unique capacity to deliver the highest-quality medical care. Financing that health care system, however, remains a challenging dilemma for this country.

In recent years, the private sector has shown a remarkable ability to slow the growth in health care spending. Similarly, the Balanced Budget Act, passed by Congress in 1997, has helped slow the growth in Medicare spending.

Still, there are ominous signs on the horizon. Medicare remains unprepared for the oncoming retirement of the baby-boom generation. And, for a number of reasons, the private sector health care market is anticipating a return to double-digit growth in health care costs. After five years of near-stability, this will have a profound effect on millions of Americans.

Today this Subcommittee will examine the impact of rising costs on the problem of the uninsured. The problem of the uninsured is the most glaring flaw in our health care system. Despite record-low unemployment, there are a record number of Americans without health insurance. According to various estimates, there are forty-three million Americans without health insurance. The ranks of the uninsured are growing at nearly one million a year. This fact has great consequences for millions of American families without health insurance who run the risk of financial catastrophe.

Much political debate has, in recent months, been devoted to the issue of "patient protections." This involves the perception that some health plans are not as responsive to patient concerns as some critics would like. Critics of managed care contend that the solution to these concerns is increased regulation. However, the Congressional Budget Office (CBO) has shown that increased regulation, however well-intentioned, leads to higher costs and higher costs lead to more uninsured.

To those who would say increased regulation is the key, I would respond that the best patient protection of all is access to affordable health insurance coverage.

A return to explosive growth in health care spending will push health insurance rates up even faster. Employers—who provide health insurance to their employees—will be put in the position of having to require employees to pick up more of the costs for their policies. Employees in increasing numbers are forgoing health insurance as they see it becoming ever more expensive.

This Subcommittee will examine today the problem of the uninsured. We will begin today by hearing from a panel of experts who will help us understand the nature of the problem. Studying the origins of the problem will provide us with a lesson: adding costly regulation increases those without any coverage. Studying the nature of the problem will also help us develop more constructive, not counterproductive, solutions.

Chairman THOMAS. And, with that, I would see if my colleague from California, Mr. Stark, has any opening comments.

Mr. STARK. Mr. Chairman, I thank you for holding this hearing on the problem of the uninsured. It should take about 5 minutes. If anybody in this room doesn't know that there are somewhere between 40 and 45 million uninsured in this country, then they are probably waiting for the movie "To Fly," and that is a few blocks down the street. You are in the wrong room.

I would wish that this hearing would have been preceded—or certainly followed up by—a markup of some bills to help the uninsured. Frankly, I am sure we know enough about the problem. We know we are the only industrialized nation in the world, perhaps

the only nation in the world, that has been unable to provide insurance to all of its residents. We know that is a disgrace. We evidently don't know what we are going to do about it.

This morning 81 of us reintroduced the Medicare Early Access Act which would let uninsured between 62 and 64 buy into Medicare and the unemployed between 55 and 62 buy in. The bill is fully financed. I would urge us to have moved to a markup of that legislation, which would at least help 400,000 hard-to-insure Americans.

Tomorrow, I will testify before our Subcommittee on a proposal to provide refundable tax credits to buy guaranteed-issue, community-rated group insurance policies. Unlike other proposals, this bill will work because it reforms the insurance market, something no other bill dares to do. The key will be how to finance it. To end the national disgrace of uninsurance, I propose using some of our surplus, plus a tax increase on those employers who do not provide comparable insurance coverage for their workers.

Another solution would be to dedicate the next minimum wage increase to paying for workers' health insurance. Some cities in California are already doing that.

Others of us, like Representative McDermott, have proposed a single-payer system. Representative Kleczka is working on a bill to help retirees who have been dropped by their companies. I would urge a hearing on any or all of the solutions, including the idea of just gradually lowering the Medicare age of eligibility and gradually raising the payroll tax to pay for lifetime universal coverage.

The witnesses have only been asked to discuss the problem. I certainly hope that, if there is anything unique about the problem of uninsured, they will suggest their preferences for a solution. This problem has been around for a long time. I gather the Republicans have just recognized it. And I certainly hope that it won't take them more than 15 minutes to count the 40 million some-odd uninsured and let us get to the point where we talk about solving the problem.

Thank you.

[The opening statements follow:]

Opening Statement of Hon. Fortney Pete Stark, a Representative in Congress from the State of California

Mr. Chairman:

Thank you for holding this hearing on the problem of the uninsured.

I hope it will be followed, soon, with mark-up of bills to actually help the uninsured.

Frankly, I think we know enough about the problem.

We know we are the only major industrialized nation in the world that has been unable to solve this problem—and we *should* know that that is a disgrace.

What are we going to do about it?

This morning, 81 of us re-introduced the Medicare Early Access Act, which would let uninsured between 62 and 64 buy into Medicare, and the unemployed between 55 and 62 buy-in. The bill is fully financed by a package of Medicare anti-fraud initiatives, and over time, this anti-fraud package actually reduces Medicare's long-term deficits. I urge us to move to mark-up of this legislation, which is estimated to help provide 400,000 hard-to-insure Americans with dependable care.

Tomorrow, I am testifying before the full Committee on a proposal to provide refundable tax credits to buy guaranteed-issue, community-rated, group insurance policies. Unlike other proposals, this bill will work because it dares to reform the insurance market. The key will be how to finance it. To end the national disgrace of un-insurance, I propose using some of the surplus plus a tax increase on those

employers who do not provide comparable insurance coverage for their workers. Another solution would be to dedicate the next minimum wage increase to paying for workers' health insurance.

Others of us, like Rep. McDermott, have proposed a single payer type system. Rep. Kleczka is working on a bill to help the retirees who have been dropped by their companies. I would urge a hearing on any and all of these solutions, including the idea of just gradually lowering the Medicare age of eligibility and gradually raising the payroll tax rate to pay for life-time, universal coverage.

Even though the witnesses have been asked only to discuss "the problem" of the uninsured, I hope that they will go beyond that and indicate their preferences for a solution.

Opening Statement of Hon. Jim Ramstad, a Representative in Congress from the State of Minnesota

Mr. Chairman, thank you for calling this important hearing to learn more about individuals lacking health insurance in America today.

As Congress focuses attention on mandating various benefits within a health insurance plan, we must keep in mind the importance of having health insurance in the first place. One thing I am reminded whenever I meet with small employers in my district is that "patient protections" mean nothing if you can't afford health insurance coverage.

I am proud of this Committee's attention to this issue. Legislation passed in 1996 under Chairman Thomas' leadership created Medical Savings Accounts (MSAs). MSAs are the premier example of affordable, patient-driven health care options and have given thousands of uninsured individuals in this country access to affordable, high quality health care. I am hopeful we can remove the unnecessary restrictions surrounding these truly patient-oriented plans soon for many of their colleagues who still remain priced out of the health insurance market.

While Minnesota has done a fairly good job at increasing access to health insurance, I know more work needs to be done in my state and across the country. For example, I am hopeful we, along with our colleagues on the full Committee, are able to provide greater tax incentives for health care expenses. In addition, we must review proposals to stem the rise in health care costs, such as medical malpractice reform, increased competition in the market and relief from burdensome government rules and regulations.

I look forward to learning more from our witnesses about the factors that contribute to the number of uninsured in America today, as well as ways to significantly reduce those numbers.

Chairman THOMAS. The Chair recognizes some people may have the answer, but for some of us, I appreciate Dr. Fronstin; Grace-Marie Arnett; John Sheils, Lewin Group; and John Holahan of the Health Policy Center. Any written testimony you may have will be made a part of the record and during the time available to you, you may address us in any way you see fit. We will start with Dr. Fronstin and then move across the panel.

STATEMENT OF PAUL FRONSTIN, PH.D., SENIOR RESEARCH ASSOCIATE AND DIRECTOR, HEALTH SECURITY AND QUALITY RESEARCH PROGRAM, EMPLOYEE BENEFIT RESEARCH INSTITUTE

Mr. FRONSTIN. Thank you, Mr. Chairman.

Chairman THOMAS. And I would just say that if, in fact, we allot roughly 5 minutes each, tell the gentleman from California, that would be about 20 minutes instead of the 15 that he felt was necessary.

Dr. Fronstin.

Mr. FRONSTIN. Thank you, Mr. Chairman. Mr. Chairman, Members of the Subcommittee, my name is Paul Fronstin. I am director of the Health Security and Quality Research Program at the Employee Benefit Research Institute and I am pleased to appear before you today to discuss uninsured Americans.

Between 1987 and 1997, the percentage of Americans without health insurance coverage increased from just under 15 percent to now over 18 percent and, as we have already heard, it is about 43 million nonelderly Americans. When examining this trend, it is important to recognize that the determinants underlying it are different in the pre-1993 period than in the post-1993 period. Prior to 1993, the uninsured was increasing in large part because the percentage of Americans covered by an employment-based plan was declining. The erosion of employment-based health insurance was in large part due to rising health care costs, resulting in small employers dropping insurance and large employers shifting the costs of coverage onto workers.

Between 1993 and 1997, health insurance costs increased modestly and health care costs were in line with overall inflation. Low health care cost increases and the strong economy did have an effect on employment-based coverage levels and the uninsured during this period. Unlike the period prior to 1993, between 1993 and 1997, the percentage of nonelderly Americans covered by employment-based plans increased. The period since 1993 is unique. It is likely the first time in history that the U.S. population was experiencing an increase in the uninsured population while the percentage of Americans covered by an employment-based health plan was also increasing. Researchers have yet to completely understand this trend, but speculation has been offered.

The growth rate in the uninsured population has slowed since 1993 and may also be attributable to modest health insurance cost increases. Between 1987 and 1993, health insurance costs increased an average of over 13.5 percent per year. During this period, the uninsured increased an average of 2.6 percent per year. In contrast, between 1994 and 1997, when health insurance costs increased an average of 2.9 percent per year, the uninsured increased an average of 1.4 percent per year.

When examining the uninsured, it is important to understand that some uninsured workers are offered health insurance by their employer while others are not. In 1996, 24 percent of uninsured workers were offered health insurance by their employer; an additional 5.1 percent could have received coverage through a family member. With an effective access rate of about 29 percent, it is likely that over 12.5 million of the 43.1 million uninsured do have access to an employment-based health plan.

The proportion of the nonelderly population with and without health insurance varies by geographic region. In 14 States, 20 percent or more of the population was uninsured in 1997. These States are in large part concentrated in the south central and southwestern parts of the United States. Young individuals are typically more likely to be uninsured than older individuals. Many in this group may think that they do not need health insurance because their probability of encountering a high-cost medical event is very low.

The uninsured are concentrated disproportionately in low-income families. Thirty-seven percent of individuals in families with income just above the poverty line were uninsured in 1997. This compares with only 8 percent uninsured among individuals in families with income at 400 percent or more of the poverty level.

Approximately 84 percent of the uninsured were members of families with a working head of household in 1997. As a result, it is just as important to understand the job characteristics of uninsured workers as it is to understand the characteristics of the uninsured in general. Workers employed in small firms are more likely to be uninsured than workers employed in large firms. As a result, over 60 percent of uninsured workers were employed in firms with less than 100 employees or were self-employed in 1997.

Finding solutions for reducing the level of the uninsured is like trying to hit a moving target. While the characteristics of the uninsured population do not vary much from year to year, the people within that population do change. A recent EBRI study found that most uninsured spells were either very long or very short. Specifically, 37 percent of all uninsured spells lasted 4 months or less while 33 percent lasted 12 months or longer. Spells were more likely to last longer than 4 months for the following groups: Hispanics, individuals 25 years and older, the self-employed, workers not employed in manufacturing or the public sector, and individuals with long spells of unemployment.

This concludes my statement. I do appreciate the opportunity to testify today. I would be happy to answer any questions you have and I look forward to working with the Subcommittee in the future if you have additional questions.

Thank you.

[The prepared statement follows:]

Statement of Paul Fronstin, Ph.D., Senior Research Associate and Director, Health Security and Quality Research Program, Employee Benefit Research Institute

Mr. Chairman, ranking member, and members of the Committee, I am pleased to appear before you today to discuss uninsured Americans. My name is Paul Fronstin. I am a senior research associate and director of the Health Security and Quality Research Program at the Employee Benefit Research Institute (EBRI), a private, nonprofit, nonpartisan, public policy research organization based here in Washington, DC. EBRI has been committed, since its founding in 1978, to the accurate statistical analysis of economic security issues. Through our research we strive to contribute to the formulation of effective and responsible health and retirement policies. Consistent with our mission, we do not lobby or advocate specific policy solutions.

INTRODUCTION

Between 1987 and 1997, the percentage of Americans without health insurance coverage increased from 14.8 percent to 18.3 percent, and now comprises 43.1 million nonelderly Americans (chart 1 & table 1). However, when examining this increase it is important to recognize that the determinants underlying the trend are different in the pre–1993 period than the post–1993 period. Prior to 1993, the uninsured was increasing in large part because the percentage of Americans covered by an employment-based health plan was declining. In 1987, 69.2 percent of the nonelderly Americans were covered by an employment-based health plan (chart 2 and table 1). That was down to 63.5 percent by 1993. The erosion of employment-based health insurance was in large part due to rising health care costs, resulting in small

employers dropping insurance and large employers shifting the cost of coverage onto workers.[1]

Table 1

NONELDERLY AMERICANS WITH SELECTED SOURCES OF HEALTH INSURANCE COVERAGE, 1987–1997

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997[a]
						(millions)					
Total Population	214.4	216.6	218.5	220.6	222.9	225.5	228.0	229.9	231.9	234.0	236.2
Total Private	162.8	162.9	164.3	162.1	161.3	160.5	161.5	162.8	163.9	165.8	167.5
Employment-based coverage	148.5	149.4	149.8	147.7	147.7	145.9	144.9	146.3	147.9	149.8	151.7
own name	72.5	73.5	74.0	73.1	73.1	71.7	74.9	75.2	75.9	76.9	77.4
dependent coverage	75.9	75.9	75.8	74.7	74.6	74.3	69.9	71.1	72.1	72.9	74.3
Other private coverage	14.3	13.5	14.5	14.3	13.6	14.6	16.6	16.4	16.0	16.0	15.8
Total Public	28.5	28.8	28.7	31.9	34.4	36.0	38.1	38.9	38.4	37.4	34.9
Medicare	3.1	3.2	3.2	3.4	3.5	3.9	3.7	3.7	4.1	4.6	4.7
Medicaid	18.4	18.9	19.2	22.4	24.8	26.5	29.0	28.7	29.0	28.2	26.0
CHAMPUS/CHAMPVA[b]	8.5	8.2	7.9	7.9	7.9	7.5	7.4	8.7	7.4	6.8	6.6
No Health Insurance	31.8	33.6	34.3	35.6	36.3	38.3	39.3	39.4	40.3	41.4	43.1
						(percentage)					
Total Population	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total Private	75.9	75.2	75.2	73.5	72.4	71.2	70.8	70.8	70.7	70.9	70.9
Employment-based coverage	69.2	69.0	68.6	67.0	66.3	64.7	63.5	63.6	63.8	64.0	64.2
own name	33.8	33.9	33.9	33.1	32.8	31.8	32.9	32.7	32.7	32.9	32.8
dependent coverage	35.4	35.0	34.7	33.8	33.5	32.9	30.7	30.9	31.1	31.2	31.5
Other private coverage	6.7	6.3	6.6	6.5	6.1	6.5	7.3	7.1	6.9	6.8	6.7
Total Public	13.3	13.3	13.2	14.5	15.5	16.0	16.7	16.9	16.6	16.0	14.8
Medicare	1.4	1.5	1.5	1.6	1.6	1.7	1.6	1.6	1.8	2.0	2.0
Medicaid	8.6	8.7	8.8	10.2	11.1	11.8	12.7	12.5	12.5	12.1	11.0
CHAMPUS/CHAMPVA[b]	4.0	3.8	3.6	3.6	3.5	3.3	3.3	3.8	3.2	2.9	2.8
No Health Insurance	14.8	15.5	15.7	16.1	16.3	17.0	17.3	17.1	17.4	17.7	18.3

Source: Employee Benefit Research Institute estimates of the March 1988–1998 Current Population Survey.

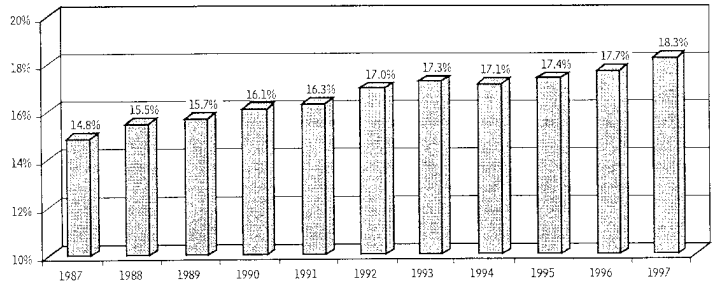
Note: Details may not add to totals because individuals may receive coverage from more than one source.

[a]Medicaid and uninsured data are not completely consistent with data from previous years. Starting with the March 1998 Current Population Survey, the Bureau of the Census modified its definition of the population with Medicaid and the population without health insurance coverage. Previously, individuals covered solely by the Indian Health Service were counted in the Medicaid population. Beginning with data from the March 1998 CPS, individuals covered solely by the Indian Health Service are counted as uninsured. This change decreased the Medicaid population and increased the uninsured population by 300,000, or 0.2 percent.

[b]Civilian Health and Medical Program of the Uniformed Services and the Civilian Health and Medical Program of the Department of Veterans' Affairs.

Chart 1

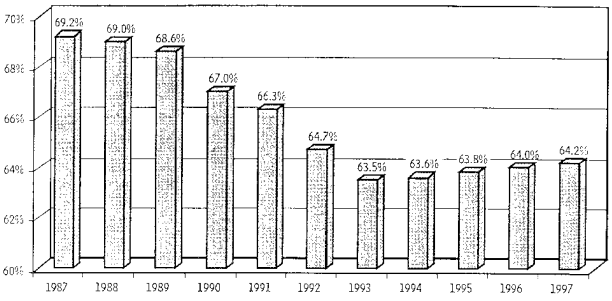
PERCENTAGE OF NONELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 1987–1997



Source: Employee Benefit Research Institute estimates of the March 1988-1998 Current Population Survey.

[1] The decline in coverage was also the result of declining real income and structural changes in the economy, such as the movement of workers from the manufacturing sector to the service sector, the increased use of part-time workers, and the decline of unionization (Fronstin and Snider, 1996/97).

Chart 2
PERCENTAGE OF NONELDERLY AMERICANS COVERED BY AN EMPLOYMENT-BASED HEALTH PLAN, 1987–1997

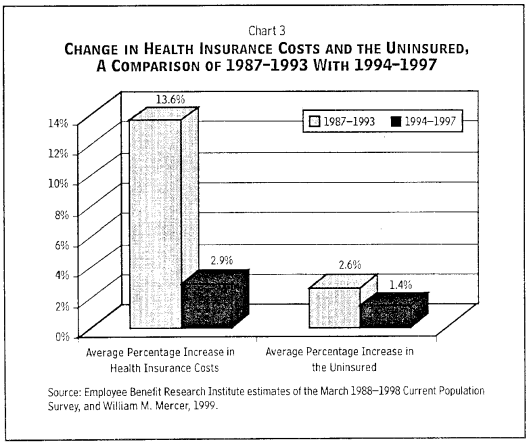


Source: Employee Benefit Research Institute estimates of the March 1988–1998 Current Population Survey.

Between 1993 and 1997, health insurance costs increased modestly and health care costs were in line with overall inflation. According to an annual survey by William M. Mercer, health insurance costs declined in 1994, increased 2.1 percent in 1995 and 2.5 percent in 1996, and barely increased in 1997. Low health care cost increases and the strong economy had an effect on employment-based coverage levels and the uninsured during this period. Unlike the period prior to 1993, between 1993 and 1997 the percentage of nonelderly Americans covered by an employment-based health plans increased from 63.5 percent to 64.2 percent. At the same time, the percentage of Americans without health insurance coverage continued to increase, though at a slower rate than experienced between 1987 and 1993.

The period since 1993 is unique. It is likely the first time in history that the United States population was experiencing an increase in the uninsured population while the percentage of Americans covered by an employment-based health plan was also increasing. Researchers have yet to completely understand this trend, but speculation has been offered. It appears that individuals leaving welfare (and Medicaid) because of the strong economy and welfare reform are contributing to both the increase in the uninsured and the increase in employment-based coverage. As former welfare recipients get jobs, some get jobs that offer health insurance while others get jobs that do not offer health insurance.

The growth rate in the uninsured population has slowed since 1993, and may also be attributable to modest health insurance cost increases. Between 1987 and 1993, health insurance costs increased an average of 13.6 percent per year, according to chart 3. During this period the uninsured increased an average of 2.6 percent per year. In contrast, between 1994 and 1997, when health insurance costs increased an average of 2.9 percent per year, the uninsured increased an average of 1.4 percent per year. While the uninsured did not decline, lower health insurance cost increases did result in a slowing of the growth in the uninsured.



In formulating public policy for the uninsured population, it is important to understand the characteristics of the uninsured population. The remainder of this testimony presents this information.

DATA

The data in this testimony come from three sources: the Current Population Survey (CPS) and the Survey of Income and Program Participation (SIPP), both conducted by the U.S. Bureau of the Census, and the 1996 Medical Expenditure Panel Survey (MEPS), conducted by the Agency for Health Care Policy and Research.

The CPS is conducted monthly, and health insurance status is measured by a survey of 145,000 individuals conducted in March of each year. The CPS has become the most widely used source of data on the uninsured and is the source of the estimate that 43.1 million nonelderly Americans were uninsured in 1997. This is the survey that has been used to track the uninsured since as far back as 1980. While the questionnaire has been changed in various years to improve the accuracy of the data, many researchers feel comfortable making adjustments to the data that result in a consistent time series since 1987 (See Fronstin, 1998, for more details).

The MEPS also contains data on the uninsured, but is not used as often by researchers as the CPS because it has been conducted only intermittently since 1977 (previously under the name National Medical Expenditure Survey), and because of the smaller sample size. However, data was collected in MEPS that is not collected in CPS. For example, MEPS asks workers if their employer offers them health insurance coverage and about health care utilization. Additional data on premiums, plan design, health care expenditures, and source of payment are expected to be released later this year.

SIPP contains data on the uninsured, but is not used as often as CPS for a number of reasons, primarily because of the time lag in obtaining SIPP data. The strength of using the SIPP data for analysis of health insurance coverage is that it allows researchers to track individuals for as long as 36 months. This allows researchers to conduct comprehensive analyses on duration of insurance status, some of the results of which are discussed below.

THE UNINSURED

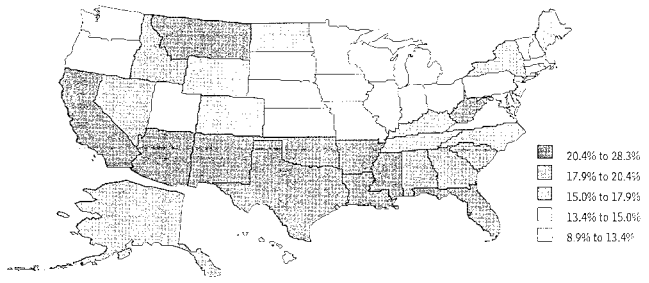
When examining the uninsured, it is important to understand that some uninsured workers are offered health insurance by their employer while others are not. For example, a 1997 study found that 24 percent of uninsured workers were offered health insurance by their own employer, while an additional 5.1 percent could have received coverage through a family member (Cooper and Schone, 1997). With an effective access rate of 29.1 percent, it is likely that over 12.5 million of the 43.1 million uninsured actually have access to an employment-based health plan.

Access to Health Insurance—This same study found that between 1987 and 1996 the percentage of workers offered an employment-based health plan increased, but take-up rates were down. The study found that while take-up rates declined across all income groups, they were down the most for low-income workers.

Geographic Region—The proportion of the nonelderly population with and without health insurance varies by geographic region. In 14 states, 20 percent or more of the population was uninsured in 1997 (chart 4). These states are in large part concentrated in the south central and southwestern parts of the United States. Many of these states have a higher concentration of minority groups, such as Hispanics, who are less likely to be covered by health insurance. The higher uninsured rates may be due in part to the fact that Hispanics are more likely to be in low-income families than other races. States with a low percentage of uninsured individuals include Hawaii, Wisconsin, Minnesota, Vermont, and Pennsylvania.

Chart 4

PERCENTAGE UNINSURED, BY STATE, 1997

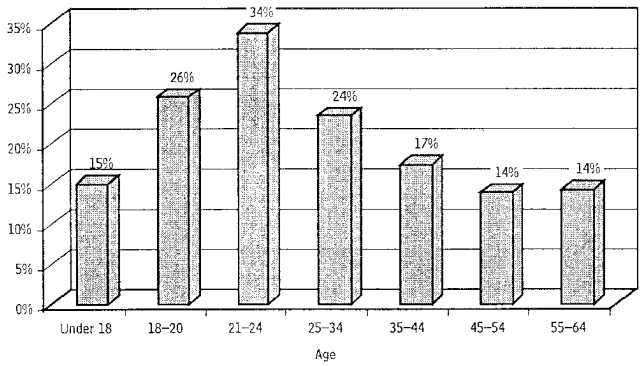


Source: Employee Benefit Research Institute estimates of the March 1998 Current Populatio

Age—Young individuals are typically more likely to be uninsured than older individuals (chart 5). This is apparent by looking at the data in chart 6, which shows that the uninsured population is disproportionately younger than the general population. The high proportion of young adults without health insurance may occur because they are no longer covered by a family policy and may not have established themselves as permanent members of the work force. Some young adults may also have lost access to Medicaid, which covered them up through age 18 in some states. Many in this group may think that they do not need health insurance because their probability of encountering a high-cost medical event is very low.

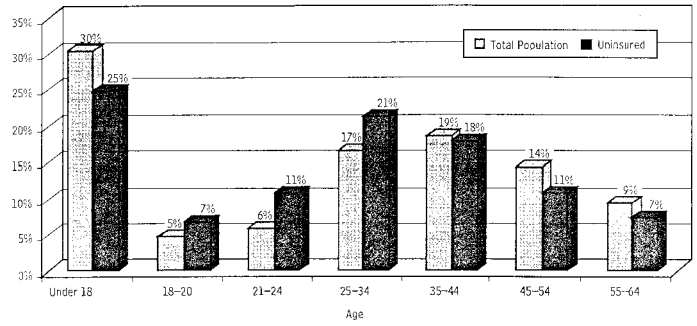
Chart 5

LIKELIHOOD OF BEING UNINSURED, BY AGE, 1997



Source: Employee Benefit Research Institute estimates of the March 1998 Current Population Survey.

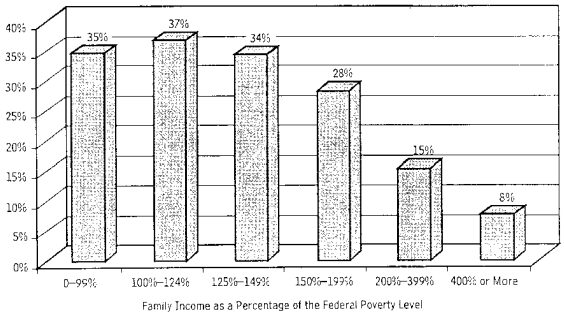
Chart 6
DISTRIBUTION OF AMERICANS AND UNINSURED AMERICANS BY AGE, 1997



Source: Employee Benefit Research Institute estimates of the March 1998 Current Population Survey.

Income—Income plays an important role in whether or not an individual is uninsured. The uninsured are concentrated disproportionately in low-income families. For example, 37 percent of individuals in families with income just above the poverty line were uninsured in 1997 (chart 7). This compares with 8 percent uninsured among individuals in families with income at 400 percent of the poverty level or more.

Chart 7
LIKELIHOOD OF BEING UNINSURED, BY FAMILY INCOME, 1997



Source: Employee Benefit Research Institute estimates of the March 1998 Current Population Survey.

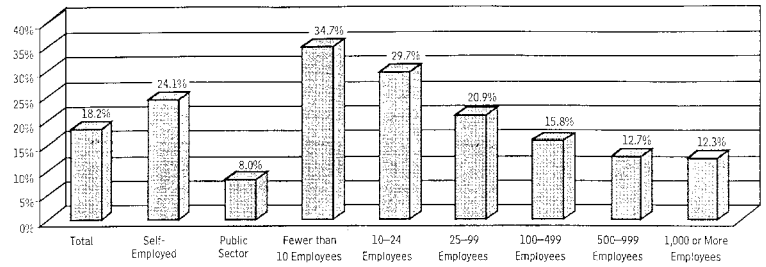
WORK STATUS

Approximately 84 percent of the uninsured were members of families with a working head of household in 1997 (Fronstin, 1998). As a result, it is just as important to understand the job characteristics of uninsured workers as it is to understand the characteristics of the uninsured in general.

Firm size—Workers employed in small firms are more likely to be uninsured than workers employed in large firms (chart 8). As a result, the uninsured is more likely to be composed of workers in small firms than the general working population. In 1997, over 60 percent of uninsured workers were employed in firms with less than 100 employees or were self-employed (98 percent of the self-employed reported a firm size of less than 100 employees). According to chart 9, 12 percent of uninsured workers were self-employed; 22 percent were in firms with less than 10 workers, 13 percent were in firms with 10–24 workers; and 14 percent were in firms with 25–99 workers.

Chart 8

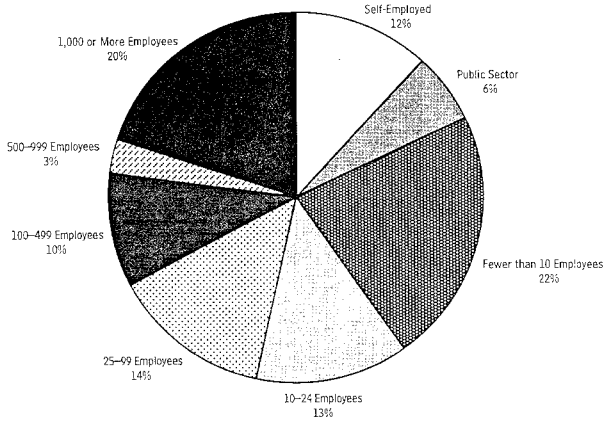
LIKELIHOOD OF WORKERS BEING UNINSURED, BY FIRM SIZE, 1997



Source: Employee Benefit Research Institute estimates of the March 1998 Current Population Survey.

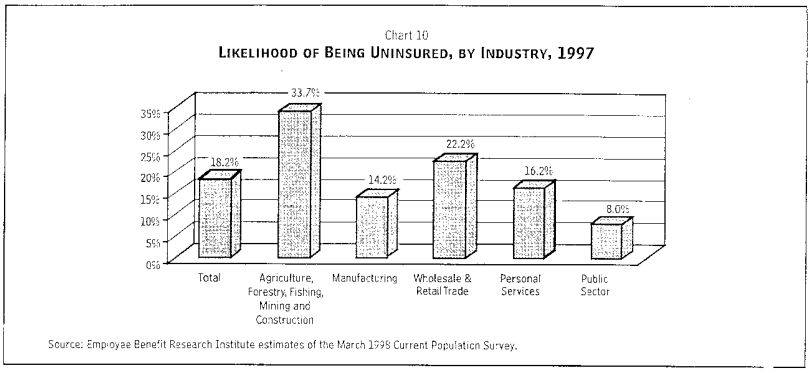
Chart 9

DISTRIBUTION OF UNINSURED WORKERS, BY FIRM SIZE, 1997



Source: Employee Benefit Research Institute estimates of the March 1998 Current Population Survey.

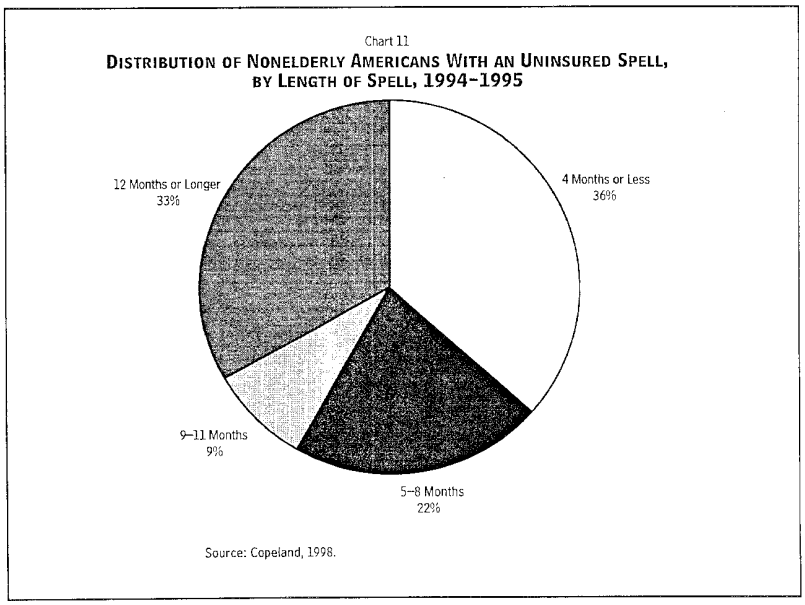
Industry—Workers employed in the public sector or the manufacturing sector were least likely to be uninsured (chart 10). Workers were more likely to be uninsured if they were employed in agriculture, forestry, fishing, mining, construction, wholesale and retail trade, or the personal service sector.



DURATION OF BEING UNINSURED

Finding solutions for reducing the level of the uninsured is like trying to hit a moving target. While the characteristics of the uninsured population do not vary much from year to year, the people within that population do change. For example, a recent study by my colleague Craig Copeland at the Employee Benefit Research Institute found that most uninsured spells were either very short or very long (Copeland, 1998). Specifically, 37 percent of all uninsured spells lasted four months or less, while 33 percent lasted 12 months or longer (chart 11). Spells were more likely to last longer than four months for the following groups:

- Hispanics.
- Individuals ages 25 and older.
- The self-employed.
- Workers not employed in manufacturing or the public sector.
- Individuals with long spells of unemployment.



Mr. Chairman, this concludes my statement. Thank you for the opportunity to testify today. I would be happy to answer any questions that you or members of the committee may have, and invite you to call on EBRI in the future for additional information.

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Copeland, Craig. "Characteristics of the Nonelderly with Selected Sources of Health Insurance and Lengths of Uninsured Spells," *EBRI Issue Brief* no. 198 (Washington, DC: Employee Benefit Research Institute), June 1998.

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Fronstin, Paul. "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief* no. 204 (Washington, DC: Employee Benefit Research Institute), December 1998.

Fronstin, Paul, and Sarah C. Snider. "An Examination of the Decline in Employment-Based Health Insurance Between 1988 and 1993," *Inquiry 33*, Winter 1996/97: 317–325.

The views expressed in this statement are solely those of the author and should not be attributed to the Employee Benefit Research Institute (EBRI), its officers, trustees, sponsors, or other staff. The Employee Benefit Research Institute is a private, nonprofit, nonpartisan, public policy research organization.

Chairman THOMAS. Thank you, Dr. Fronstin. I think there will be some questions about especially the very useful charts that you have provided with your testimony.

Ms. Arnett.

STATEMENT OF GRACE-MARIE ARNETT, PRESIDENT, GALEN INSTITUTE, ALEXANDRIA, VIRGINIA

Ms. ARNETT. Thank you, Mr. Chairman and Members of the Subcommittee, for the opportunity to testify today.

I am president of the Galen Institute. We are a not-for-profit health and tax policy research organization based in Alexandria, Virginia, working to promote a more-informed debate over individual freedom, consumer choice, competition, and diversity in the health sector.

It is frustrating to those of us in the policy community as to all of you that, despite all of the thousands of hours of effort on your part and those of State lawmakers and despite a strong and sustained period of economic growth, that the number and percentage of Americans without health insurance continue to rise. At the State level, thousands of rules and regulations have been passed with the intent of forcing insurers to offer coverage that contained good benefits at reasonable costs and with protections for policy holders. Additional insurance regulation and mandates recently have been passed at the Federal level, as you all know, and even more are being debated. However, the data increasingly show that these laws have the effect of increasing the cost of health insurance and are, in fact, driving up the number of uninsured.

People who are on the tightest budgets must make the hardest choices of deciding how to allocate their resources. After paying the rent or mortgage or putting food on the table, millions of Americans simply don't have enough money left to buy health insurance. Some are faced with the difficult choice between sending their children to good, safe schools or providing the family with the security of health insurance.

We see, increasingly, the choices that Americans are making. When asked by a Kaiser/Commonwealth Fund survey, the majority of Americans polled cited cost as the reason for not having health insurance. In fact, between 1988 and 1996, the cost of health insurance increased by 111 percent, despite an increase in the overall

consumer price index of only 33 percent. After several years of leveling off, health insurance costs are on the rise again and that certainly does not bode well for the number of uninsured.

The GAO has concluded that continued erosion of health insurance coverage is directly related to cost pressures. The Congressional Budget Office estimates that every 1 percent increase in the cost of health insurance, throws 200,000 more people off the insurance rolls. The uninsured are disproportionately young, minority, lower income, and either work for smaller companies or are their dependents. For low-income Hispanic families, 52 percent are uninsured.

The research that I have done, which is validated by numerous other experts, has convinced me that there is a causal connection. The growing burden of mandates and regulation in the health sector leads to higher costs for health insurance, which in turn, drives more people into the ranks of the uninsured. I direct you and the other Members of the Subcommittee to my testimony for a more detailed description of the specific research.

For example, Gail Jensen of Wayne State University and Michael Morrisey of the University of Alabama at Birmingham found that as many as one in four of Americans lacks health insurance because of benefit mandates. Yet the number of mandates has increased 25-fold over the last quarter century. Mandates and regulations don't show up on the Federal budget ledger, but they do show up in the paychecks and loss of coverage by individual workers. Mandates are not free. They are paid for by workers and their dependents who receive lower wages or lose coverage altogether.

Each mandate may increase costs by only 1 percentage or 2, but others add much more. Each one of these benefit mandates can be fully justified on its own merits. But cumulatively, they are condemning more and more people to being without health coverage. Small businesses and those attempting to purchase health insurance on their own are most vulnerable to these regulations because they do not have the opportunity to escape through the protection of ERISA.

The Galen Institute last year conducted a study to determine the effects of State efforts to regulate their health insurance markets and shape coverage to help their citizens get affordable health coverage. Using GAO studies, we determined that between 1990 and 1994, 16 States were most aggressive in passing laws regulating health insurance. By 1996, these 16 States were seeing their uninsured populations grow an average of 8 times faster than the 34 States that passed less comprehensive regulation. Before this blizzard of regulation, the two groups had been virtually equal. We looked at many other factors at these 16 States. The distinguishing characteristic was the passage of these very aggressive insurance regulations.

One of the biggest regulators was Kentucky. The Governor said afterward, "In spite of good intentions and noble purposes, it didn't work. The entire cost of the system went up." The findings by our study have been validated in part by other studies, including the Urban Institute.

The fact that regulation has failed at the State level does not mean Federal action is not needed, but in the battle over patient

protection legislation, the uninsured are being shoved aside in favor of a small percentage of those who have health insurance but are unhappy with it. And for the 43 million Americans with no health insurance, the data strongly suggest that patients rights legislation will hurt them by driving up the costs of coverage and throwing more people off the insurance rolls. I have provided a chart, Mr. Chairman, for the discussion of this issue.

My time has run out. I would be happy, later on, to describe the chart if you would like.

[The prepared statement follows:]

Statement of Grace-Marie Arnett, President, Galen Institute, Alexandria, Virginia

Thank you, Mr. Chairman, and members of the committee for inviting me to testify today as you address the challenge of why, despite years of effort to try to reverse the trends, more and more Americans are without health insurance.

My name is Grace-Marie Arnett, and I am president of the Galen Institute, a not-for-profit health and tax policy research organization based in Alexandria, Virginia. The Galen Institute was founded in 1995 to promote a more informed public debate over individual freedom, consumer choice, competition, and diversity in the health sector. The Galen Institute also facilitates the work of the Health Policy Consensus Group, which is composed of nearly 20 health policy experts from the major free-market think tanks, whose work I will discuss later in my testimony.

For decades, policy makers at all levels of government have been searching for ways to help Americans gain greater access to affordable health care. You and your colleagues in Washington and lawmakers in the states have spent untold thousands of hours trying to achieve that goal.

It is frustrating to you and to virtually all Americans that, despite these efforts and especially during a period of strong and sustained economic growth, the number and percentage of Americans without health insurance continues to rise. In 1987, there were 32 million Americans under age 65 without health insurance at some point during the year. A decade later, the number has risen to more than 43 million or 16.1% uninsured.

At the state level, thousands of new rules and regulations have been passed with the intent of forcing health insurers to offer coverage that contained good benefits, at reasonable costs, and with protections for policyholders. Some insurance regulations and mandates recently have been passed at the federal level, as you know, and even more are being debated. However, the rule that governs the practice of medicine should also govern lawmakers in addressing health reform issues: First, do no harm.

The data show that these laws have the effect of increasing the cost of health insurance and are driving up the number of uninsured.

INSURANCE COSTS AND THE UNINSURED

People who are on the tightest budgets must make the hardest choices in deciding how to allocate their resources. After paying the rent or the mortgage and putting food on the table, millions of Americans simply don't have enough money left to buy health insurance. Some are faced with the choice between sending their children to a good, safe school or providing the family with the security of health insurance. These are terribly difficult choices, but we see from the numbers the choice that more and more Americans are making.

When asked by a Kaiser/Commonwealth Fund survey, the majority of Americans cite cost as their reason for not having health insurance.

Over the last decade, health insurance costs have increased much faster than overall consumer prices. The General Accounting Office reported in 1997 that the average annual premium for employment-based family health insurance coverage increased by 111%, from $2,530 in 1988 to $5,349 by 1996. During this same period, overall consumer prices rose by 33%.[1] Now, after several years of leveling off, health insurance premiums are on the rise again. This does not bode well for the uninsured.

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[1] U.S. General Accounting Office. "Private Health Insurance. Continued Erosion of Coverage Linked to Cost Pressures," GAO/HEHS–97–122. July 1997. Washington, D.C.

The GAO concluded that the continued erosion of health insurance coverage is directly linked to cost pressures.

The Congressional Budget Office estimates that every one percent increase in the cost of health insurance throws 200,000 more Americans off the insurance rolls. The result: Those who can least afford the inevitable premium increases will lose their health insurance.

The uninsured are disproportionately young, minority, lower income, and either work for small companies or are their dependents.[2] Hispanics and minorities are the most likely to be uninsured. Among working-age Americans, 14% of whites, 24% of blacks, and 38% of Hispanics are uninsured.[3] The uninsured numbers are even higher for lower-income minority group members, reaching 52% for Hispanic families whose incomes are below the federal poverty level.

The research that I have done, which is validated by numerous other experts, has convinced me that there is a causal connection: the growing burden of mandates and regulation in the health sector leads to higher costs for health insurance which, in turn, drives more people into the ranks of the uninsured.

MANDATES AND THE UNINSURED

The link between insurance mandates and the uninsured has been established by numerous researchers.

- Using data from 1989 to 1994, Sloan and Conover[4] found that the higher the number of coverage requirements placed on plans, the higher the probability that an individual would be uninsured, and the lower the probability that people would have any private health insurance coverage, including group coverage. After more than 100,000 observations, they conclusively demonstrated that the probability an individual will be uninsured increases with each mandate imposed by government.
- Gail A. Jensen of Wayne State University and Michael Morrisey of the University of Alabama-Birmingham[5] found that as many as one in four Americans lack health insurance because of benefit mandates. Each additional mandate significantly lowers the probability that a firm or an individual will have health insurance.
- Professor William S. Custer of Georgia State University[6] found that state guaranteed issue requirements, coupled with either community rating or rate bands in the small group insurance market, increase the probability that a person will be uninsured by nearly 29%. These laws hit small firms and individuals purchasing insurance in the open market the hardest.

The number of mandates has increased 25-fold over the last quarter century, with more than 1,000 state mandated benefit laws on the books today. Most are an attempt by lawmakers to correct inefficiencies or inequitable practices in the market. Unfortunately, they are having the unintended effect of increasing the ranks of the uninsured.

Mandates and insurance regulations do not show up on the federal budget ledger, but they do show up in the paychecks and in loss of coverage by individual workers. Jensen and Morrisey say, "Mandates are not free. They are paid for by workers and their dependents, who receive lower wages or lose coverage altogether."[7]

In a study, conducted in 1989 even before the explosion of state mandated benefit laws in the 1990s, Acs *et al* found that mandates significantly raised premium costs. Even then, insurance was found to be 4 to 13 percent more expensive as a direct result of benefit laws.[8]

Each mandates may increase costs only a percentage or two, but others add much more. Every one of these benefit mandates can be justified individually, and each has a constituency that can and does argue passionately for its merit. But cumulatively, they are condemning more and more people to being without health coverage.

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[2] Hall, Allyson G., Karen Scott Collins, and Sherry Glied, "Employer-Sponsored Health Insurance: Implications for Minority Workers." The Commonwealth Fund, February 1999. New York.

[3] Commonwealth Fund analysis of 1997 *Current Population Survey.*

[4] Sloan, Frank A. and Christopher J. Conover, "Effects of State Reforms on Health Insurance Coverage of Adults," *Inquiry.* 35:280–293, 1998.

[5] Jensen, Gail A., Michael A. Morrisey. "Mandated Benefit Laws and Employer-Sponsored Health Insurance." Published by the Health Insurance Association of America, January, 1999. Washington, D.C.

[6] Custer, William S. "Health Insurance Coverage and the Uninsured." Published by the Health Insurance Association of America, December 1998. Washington, D.C.

[7] Jensen, Morrisey.

[8] Acs, Gregory, Colin Winterbottom, and Sheila Zedlewski, "Employers' Payroll and Insurance Costs: Implications for Play or Pay Employer Mandates," in *Health Benefits and the Workforce.* Washington, D.C. U.S. Department of Labor, 1992.

HITTING THE MOST VULNERABLE THE HARDEST

Small businesses and individuals attempting to purchase health insurance are hit with the full force of these mandates and insurance regulations. The small group and individual insurance markets have become fragile and expensive as a result. Most large companies avoid benefit mandates and state insurance regulation laws because they are protected by ERISA, the Employee Retirement Income Security Act of 1974 that allows companies that self-insure to escape the reach of these state insurance laws and regulations. Few small business can afford to self insure and are therefore subject to all of the mandates and regulations imposed by the states.

Surveys conducted by the National Federation of Independent Business show that the great majority of small business owners would like to offer health insurance, but say high costs make it prohibitive. About 40% of businesses with fewer than 50 workers do not offer health insurance. A person working for a company with fewer than 10 employees is three times more likely to be without health insurance than someone working for a company with more than 1,000 employees.

Even small companies that do offer insurance often must make the choice between keeping their business going and offering health benefits. Many walk the line—offering insurance but requiring employees to pay a larger share of the premiums. Unfortunately, an increasing number of people offered health insurance through their jobs are declining coverage, again citing costs as the primary reason.

For this and other reasons, the number of people with private health insurance has been declining for nearly two decades. Since 1980, the number of people with private health insurance coverage obtained either through the workplace or purchased individually has been declining, from 79.5% in 1980 to 70.5% in 1995.

STATE INSURANCE REGULATIONS AND THE UNINSURED

The Galen Institute conducted a study last year,[9] which was published by The Heritage Foundation, to determine the effect of state efforts to regulate their health insurance markets and shape coverage to help their citizens get affordable health insurance coverage.

Using GAO studies, we determined that between 1990 and 1994, 16 states were most aggressive in passing laws regulating health insurance. By 1996, these 16 states were seeing their uninsured populations grow an average of EIGHT times faster than the 34 states that passed less comprehensive regulations. Compare this to 1990, before the blizzard of health-care reform legislation began, when the two groups of states had nearly equal rates of growth in their uninsured populations.

Could the increase in the number of uninsured in these 16 states be caused by something other than regulation? Not likely. The regulating states had employment and income characteristics similar to the rest of the nation. Their only distinguishing feature was the passage of these sweeping health insurance regulations.

One of the biggest regulators was Kentucky. "In spite of good intentions and noble purpose, it didn't work ... The entire cost of the system went up," Gov. Paul Patton said last year. Kentucky citizens paid the price: 107,500 fewer citizens, out of a population of 3.4 million, had health insurance in 1996 than in 1990. "In my opinion, most of the general assembly believes that we in Kentucky have experimented enough for the time being," Patton said.

In addition to Kentucky, the other states that imposed the most aggressive regulations were Idaho, Iowa, Louisiana, Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Utah, Vermont and Washington. Their new laws included: mandates on insurers to sell policies to anyone who applies and agrees to pay the premium—even if they wait to buy insurance until they are already sick (guaranteed issue); prohibitions on excluding coverage for some medical conditions (pre-existing condition exclusions); and requirements that insurers charge the same price to everyone in a community, regardless of the differences in risk posed by individuals (community rating); plus others.

The findings from our study have been validated in part by other studies, including the Urban Institute.[10]

Recent federal legislation—the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997—have imposed at the federal level some of the insurance rules that had been enacted by the states, including guaran-

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[9] Schriver, Melinda, and Grace-Marie Arnett. "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," The Heritage Foundation, August, 1998, Washington, D.C.

[10] Marstellar, Jill A., Len M. Nichols, Adam Badawi, *et al.* "Variations in the Uninsured: State and County Level Analyses." Urban Institute, June 1998. Washington, D.C.

teed renewal and some of the most common coverage mandates, making it difficult to do a differential study now.

However even now, 11 of the 16 states we studied still has a rising number of uninsured, and for all but two, the growth in their insured populations is under 1%.

The fact that regulation has failed at the state level does not mean federal action is unneeded. But in the battle over Patient Protection legislation, the uninsured are being shoved aside in favor of the small percentage of those who have health insurance but are unhappy with it. Instead of *helping* the 43 million Americans with no health insurance, the data strongly suggest that patients' rights legislation will hurt them by driving up the cost of coverage and throwing even more people off the insurance rolls.

MORE REGULATION IS NOT THE ANSWER

The health sector is the most heavily regulated industry of the American economy. In every other industry, Americans recognize that regulation drives up prices, restricts innovation, dries up competition, and forces businesses to cater to regulators and not consumers. That is exactly what is happening in the health sector.

These data show that American citizens are paying a high price for the mistakes of well-intended but flawed legislation that has backfired in its intent. A poll released last year by the Charlton Research Company showed that 66% of respondents said they thought health care is regulated enough. Only 25% said more regulation was the answer, and the majority of *them* changed their minds if the regulations would increase government bureaucracy or health care costs.

A FRESH APPROACH TO ENERGIZE THE FREE MARKET

As costs and the number of uninsured continue to rise, a different approach clearly is needed. In a forthcoming book, entitled *Empowering Health Care Consumers through Tax Reform*,[11] the Health Policy Consensus Group explores the intersection of health and tax policy for solutions. This group of economists and other health policy advisers, business group and union representatives, physicians, and political leaders describes the distortions to the health care system caused by a 50-year-old provision in the tax code.

The central, structural defect impacting the market for private health insurance is the discriminatory tax treatment of health insurance. To begin to stem the flow of problems that wind up on their doorsteps, legislators can begin by providing broader access to health insurance through tax credits and other fixed incentives for individuals.

In today's information age economy, an increasing number of people work part-time, are contract workers, or are starting their own businesses. These are the people who are disproportionately likely to be uninsured because the system is working against them.

The federal tax code heavily favors workers fortunate enough to get their health insurance through the workplace. That is because workers do not pay taxes on the part of their compensation package that they receive in the form of health benefits as long as their employer purchases the policy for them. This generous subsidy, worth an estimated $111 billion a year, is the cornerstone of the system in the United States that ties private health insurance to the workplace.

However, this tax provision distorts the efficiency of the health care market in a number of ways: (1) It restricts employees' choices to the selection the employer offers; (2) It undermines cost consciousness by hiding the true cost of insurance and medical care from employees; (3) Because the full cost of health insurance is not visible to employees, it artificially supports increased demand for medical services and more costly insurance; (4) As a result, inefficient health care delivery is subsidized at the expense of efficient delivery; (5) Cash wages are suppressed; (6) Many employees with job-based coverage are frustrated because they have little choice and control over their policies and their access to medical services; (7) The self-employed, the unemployed, and those whose employers do not offer health insurance are discriminated against because they receive a much less generous subsidy, if any at all, when they purchase health insurance on their own.

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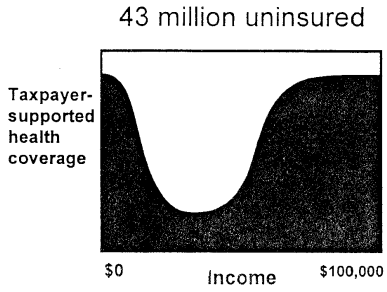
[11] Arnett, Grace-Marie, Ed. *Empowering Health Care Consumers through Tax Reform,* University of Michigan Press, Ann Arbor. Forthcoming.



TRAPPED IN THE GALEN GAP

The Galen logo is a conceptual depiction of a central problem in the health sector that affects Americans under age 65. The vertical axis of the graph in the logo represents the value of the taxpayer-supported health benefits a given individual may receive. The horizontal axis represents the individual's income.

Those with the very lowest incomes are most likely to qualify for taxpayer-supported health programs, especially Medicaid. But as an individual moves up the income scale, the likelihood of qualifying for public programs to receive health benefits drops off. Working Americans with incomes of less than $25,000 are most likely to be uninsured and are caught in the troth, which we call the "Galen Gap." They earn too much to qualify for public programs but are less likely to have the good jobs that provide health insurance as a tax-free benefit.

As people move up the income scale, they are much more likely to have both the good jobs and the higher incomes to qualify for the generous tax subsidy for employment-based health insurance, worth an estimated $111 billion this year.

John Sheils of the Lewin Group estimates that families making less than $15,000 a year reap just $71 in tax benefits from job-based health insurance while families making $100,000 or more get a $2,357 in tax break for the purchase of health insurance.[12] This is a highly regressive subsidy that drives many of the problems involving cost and access in the health sector today.

The great majority of the uninsured are in the "Galen Gap." Some have been trying to fill this gap from the left by creating and expanding government programs, such as the $48 billion State Children's Health Insurance Program and working to expand Medicare to middle-aged Americans.

We believe real solutions will come from exploring solutions on the right side of the chart—by focusing on tax policy. We believe that many more people would have access to medical services and health insurance that would be more affordable and more innovative if the tax treatment of health insurance were reformed.

Federal legislators can begin building incentives for a better system and also undo some of the damage done by federal and state regulation by providing targeted tax credits to the uninsured to purchase their own health insurance.

States can do their part by taking advantage of an immediate opportunity to provide tax credits and vouchers for uninsured children and their families through the Children's Health Insurance Program.

There is a need to provide alternative grouping mechanisms for individuals in purchasing health insurance to give them an opportunity to take advantage of group rates. A number of provisions are being debated today, such as HealthMarts and Association Health Plans, designed to address the supply-side of the equation.

Today, consumers are denied the choice of health plans best suited to their needs when mandates force plans to provide an array of benefits designed more to please lobbyists than consumers. Mandates also drive up health care costs making insurance more costly for individuals and families. Congress would be well advised to put a moratorium on more mandates until the cost and implications can be fully explored.

The results examined in these studies show that regulation at the state and federal level is counterproductive in responding to the challenge of increasing access to health insurance in the individual and private health insurance market. If health care access and affordability are genuine goals, a far better approach would be to empower individuals and families to make health care choices that suit their own

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[12] Sheils, John, and Paul Hogan. "Cost of Tax-Exempt Health Benefits in 1998," *Health Affairs.* March/April 1999. Volume 18, No. 2. Bethesda, MD.

needs, restore the independence and integrity of the medical profession, and force the health care industry and insurance companies to compete for consumers' dollars. The health care delivery system at all levels should be accountable directly to the individuals and families being served.

Thank you for the opportunity to present this testimony, and I would be happy to answer questions or provide additional information.

Chairman THOMAS. Thank you very much, Ms. Arnett.

Mr. Sheils.

STATEMENT OF JOHN SHEILS, VICE PRESIDENT, LEWIN GROUP, FALLS CHURCH, VIRGINIA

Mr. SHEILS. Thank you, Mr. Chairman. Mr. Stark is right, of course. The number of uninsured is well-understood throughout the country. But I think the characteristics of the uninsured are not that well-understood and that is important because that will have a bearing on the types of programs we need to put together to address that population. Today I am going to discuss the growth of the uninsured population, the characteristics of the uninsured, and, interesting, will identify some coverage opportunities that are currently being declined by the uninsured.

On the next page of my testimony, figure one, we have data on the uninsured going back to 1980. The number of uninsured increased from about 24 million in 1980 to 43 million by 1997. Over that period, the number of uninsured has grown at a rate of about 1 million persons per year. At that rate, we project the number of uninsured to reach 54 million by the year 2007.

The data used to develop the estimates I just showed you are actually somewhat controversial. The Bureau of the Census data that they use actually underreports the number of Medicaid recipients by about 18 percent and those persons are erroneously classified as uninsured. When you correct for that, the number of uninsured comes down to about 38 million. In addition, Congress has a health insurance program in the pipeline right now with The Children's Health Initiative that we believe would reduce the number of insured by something in the neighborhood of 2.1 million children. If you account for those two factors, the number of uninsured that we are working with is closer to 36 million.

The important point here is that, while different people have different opinions on what set of numbers of use, all of those numbers show a continuing rise in the uninsured population, something in the neighborhood of 1 million persons per year.

The uninsured: What do there incomes look like? About 38.5 percent of the uninsured have incomes below 150 percent of the poverty level. However, interestingly, we have 40.7 percent of the population are in middle-income groups, ranging from $20,000 to $50,000. The uninsured problem is fast becoming, has become, a problem for the middle-class American. One of the things we find here which is particularly disturbing, really, is that there are about 7.1 million uninsured, about 20 percent of the uninsured, are in families with incomes in excess of $50,000. That is an income level where, arguable, some level of insurance would be affordable.

We also estimate that, of the 36 million uninsured, about 4.8 million would be persons who are actually eligible for either Medicaid

or CHIP, the Children's Health Insurance Program, who have decided not to enroll. And three-quarters of these people will be children.

One of the most surprising figures in our work with this new data that has become available is we estimate there are about 10.2 million uninsured persons who have access to employer-sponsored coverage but do not take it. There are about 3.4 million workers who have declined coverage at work and have been left uninsured. They have about 2.8 million uninsured dependents. In addition, there are about 4 million children in families where the parent has taken the employer coverage offered at their place of work, but they have declined the family coverage option. Often that is because the employer will say: I'll help you pay for the worker's insurance, but the family is going to have pay for the full amount of family coverage costs.

One of the apparent culprits in this is not just the rise in health care costs, but, more importantly, the increasing proportion of the premium that employers are asking employees to pay for their coverage. For single coverage in 1991, a worker would pay 13 percent of the premium cost as a deduction from their paycheck. By 1996, it rose to 22 percent. That is about doubling. Family coverage grew from about 23 percent of the premium to about 31 percent of the premium. We found in a later study that each 1 percent increase in the premium prices paid, after adjusting for inflation, each 1 percent premium increase resulted in a loss in coverage of about 300,000 persons. And that is expected to continue.

So, to summarize some of the most troubling findings, first of all, the uninsured population is growing on an average of about 1 million persons per year. About 13.4 percent of the uninsured will actually be eligible for Medicaid or CHIP, but will not enroll. And about 10.2 million of the uninsured could take coverage through an employer plan, but have declined to take that coverage, presumably because of affordability issues. Finally, nearly 20 percent of the uninsured have family incomes in excess of $50,000 per year, yet do not purchase health insurance.

Thank you.

[The prepared statement follows:]

Statement of John Sheils, Vice President, Lewin Group, Falls Church, Virginia

My name is John Sheils. I am a vice president with The Lewin Group, a Washington-based consulting firm, specializing in health care finance issues. Our firm has conducted numerous studies of the financial impact of rising health care costs and the growing uninsured population. We have also performed financial analyses of various health care reform proposals for several public and private organizations.

I am appearing today as an independent health policy analyst. My testimony is my own and I am not appearing on behalf of any individual or organization.

In my testimony, I discuss the continuing growth of the uninsured population. I also discuss the characteristics of the uninsured and identify coverage opportunities that are currently being declined by many of the uninsured. At the suggestion of your staff, my testimony is presented in a bullet-point format with charts that is designed for easy reference.

THE NUMBER OF INSURED CONTINUES TO GROW

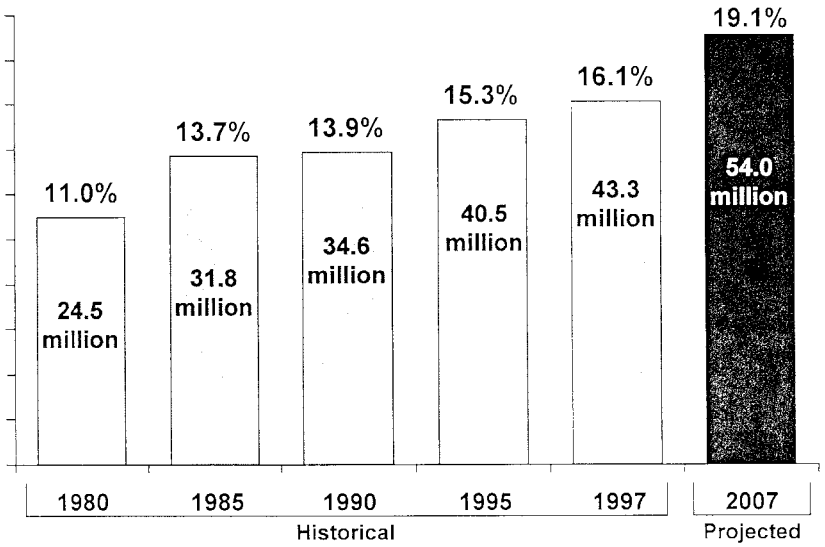
- The Bureau of the Census reports that 43.3 million Americans were uninsured in 1997. This is equal to 16.1 percent of the population.

• The number of uninsured has steadily increased for the past two decades. The number of uninsured increased from 24.5 million persons in 1980 to 43.3 million persons in 1997 (*Figure 1*).

• The number of uninsured has increased at a rate of roughly 10 million persons every decade. At this rate, the number of uninsured reported by the Bureau of the Census will grow to about 54.0 million persons by 2007, which will be equal to about 19.1 percent of the population.

Figure 1

Number and Percent of Persons Who Are Uninsured for Selected Years



Source: Lewin Group analysis of the Current Population Survey (CPS) data for 1980 through 1998.

THE CENSUS DATA OVERSTATES THE NUMBER OF UNINSURED

• About 18 percent of Medicaid recipients fail to report that they are covered by the program in the Bureau of Census data and are erroneously counted as uninsured. Underreporting is most severe for children.

• Correcting for this problem reduces the number of uninsured in 1997 from 43.3 million to 38.1 million (*Figure 2*).

• The Children's Health Insurance Program (CHIP) created under the Balanced Budget Act of 1997 will cover 2.1 million uninsured children.

• Accounting for both CHIP and underreporting reduces the number of uninsured to 36.0 million persons, of whom 6.3 million are children.

• Even with these adjustments, however, the annual increase in the number of uninsured is still expected to be about 1.0 million persons over the next ten years.

Figure 2.—Estimate of the Number of Uninsured Persons in the US

(in thousands)

	Uninsured Persons		
	Total	Children	Adults
Uninsured Persons as Reported in 1998 CPS [1]	43,329	11,211	32,118
Correction for Underreporting of Medicaid Coverage [2]	(5,227)	(2,865)	(2,362)
Expanded Eligibility under CHIP [3]	(2,071)	(2,071)	.....
Total Uninsured	36,031	6,275	29,756

[1] Based upon Lewin Group analysis of the March 1998 Current Population Survey (CPS) data, which reports insurance coverage data for 1997.

[2] Adjustment required to correct for underreporting of Medicaid coverage in the March CPS data. The CPS underreports Medicaid coverage by about 18.2 percent.

[3] Estimated number of children who ultimately will become covered under the Children's Health Insurance Program (CHIP) established under the Balanced Budget Act that is designed to extend coverage to persons with incomes of up to 200 percent of the federal poverty level (FPL).

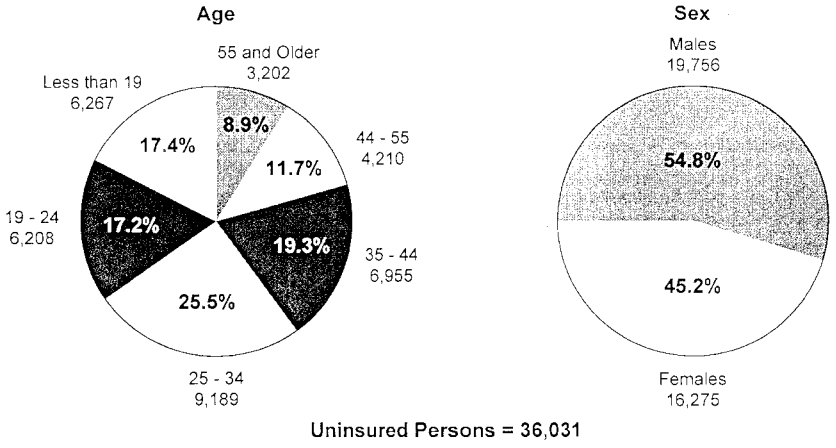
Source: Lewin Group estimates using the Medicaid Eligibility Simulation Model (MedSim) and the March 1998 Current Population Survey (CPS) data.

Many of the Uninsured are Young and Healthy Adults

- About 17.4 percent of the uninsured are children under age 19 (*Figure 3*).
- About 42.7 percent of the uninsured are young adults aged 19 to 34, even though this is the age group where premiums for adults tend to be lowest.
- About 8.9 percent (3.2 million) of the uninsured are aged 55 and older where health costs and insurance premiums can be four times greater than for an adult age 25.
- Females are less likely than males to be uninsured because many mothers and pregnant women qualify for coverage under Medicaid.

Figure 3

Distribution of Uninsured Persons by Age and Sex (in thousands)



Source: Lewin Group estimates based upon the 1998 Current Population Survey (CPS) data corrected for underreporting and adjusted for the expansion of children's coverage under CHIP using the Lewin Group Medicaid Eligibility Simulation Model (MedSim).

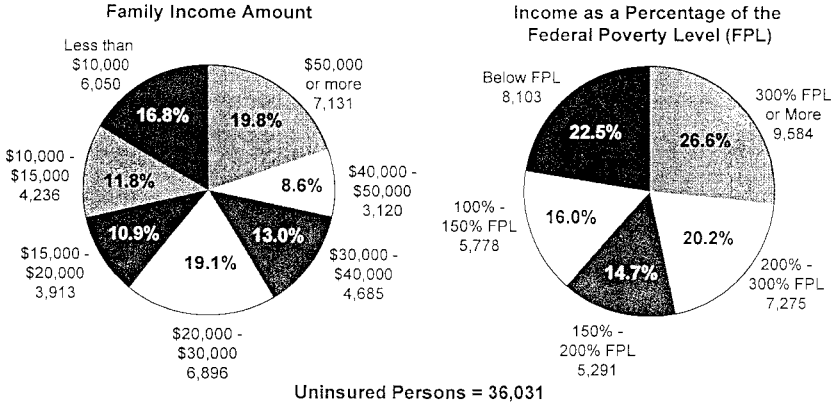
The Uninsured are Found in All Income Groups

- About 38.5 percent of the uninsured have incomes below 150 percent of the federal poverty level (*Figure 4*).
- However, about 26.6 percent of the uninsured have incomes in excess of 300 percent of the FPL.

• In fact, about 7.1 million of the uninsured (19.8 percent) are in families with incomes in excess of $50,000.
• About 40.7 percent of the uninsured are in middle income groups ranged from $20,000 to $50,000.

Figure 4

Distribution of Uninsured Persons by Income (in thousands)



Source: Lewin Group estimates based upon the 1998 Current Population Survey (CPS) data corrected for underreporting and adjusted for the expansion of children's coverage under CHIP using the Lewin Group Medicaid Eligibility Simulation Model (MedSim).

About 13.4 Percent of the Uninsured are Eligible for Either Medicaid or CHIP

• Even after CHIP is fully implemented, we estimate that 4.8 million of the uninsured (13.4 percent) will be eligible for either Medicaid or CHIP.
• Of these eligible but not enrolled persons, 3.4 million will be children.

Figure 5.—Distribution of Uninsured Persons by Income

(in thousands)

Uninsured Persons Eligible for Medicaid/CHIP Who Do Not Enroll	Number	Percent
Children under Age 19	3,445	9.6%
Adults Age 19–64	1,146	3.2%
Elderly Age 65 and Over	236	0.6%
Total	4,827	13.4%
Total Uninsured	36,031	100.0%

Source: Lewin Group estimates based upon the 1998 Current Population Survey (CPS) data corrected for underreporting and adjusted for the expansion of children's coverage under CHIP using the Lewin Group Medicaid Eligibility Simulation Model (MedSim).

About 10.2 Million Uninsured Have Access to Employer-Sponsored Coverage But Do Not Take It

• About 3.4 million uninsured persons are actually eligible to participated in their employer's health plan.
• These workers have about 2.8 million dependent spouses and children that go uninsured.
• There are another 4.0 million uninsured dependents of workers who have taken coverage at work but have not elected the family coverage option.

• Overall, about 28.5 percent of the uninsured (10.2 million) have declined the employer coverage that is available to them.

Figure 6.—Distribution of Uninsured Persons by Access to Employer Coverage in 1996 using the Medical Expenditures Panel Survey Data

Uninsured with Access to Employer Coverage	Number (in thousands)	Percent of Uninsured
Workers Who Have Declined Employer Coverage /a/	3,389	9.4%
Dependents of Workers Who Have Declined Employer Coverage	2,834	7.9%
Dependents of Covered Workers Who Have Declined Family Coverage	4,023	11.2%
Total Uninsured With Access to Employer Coverage	10,246	28.5%

/a/ The MEPS data report about 44.7 million uninsured person in the first quarter of 1996. These data reflect an underreporting of Medicaid enrollment of between 4.0 million and 5.0 million persons. These data are not directly comparable with the CPS data. MEPS data report the number of uninsured in the first quarter of the year while the CPS reports the number of persons who were uninsured for all 12 months of the year.

Source: Lewin Group analysis of the 1996 Medical Expenditures Panel Survey (MEPS) data.

MANY OF THE UNINSURED WORK

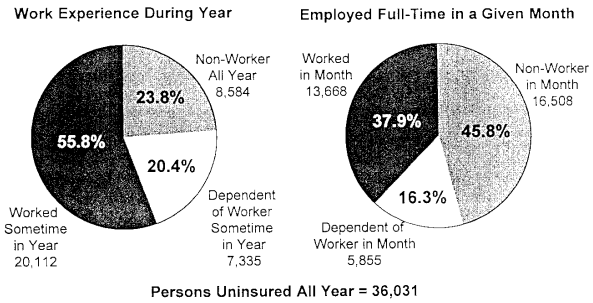
• About 76.2 percent of the uninsured are either employed or are the dependent child or spouse of a worker some time during the year (*Figure 7*).

• However, many of these individuals work only part time and for only part of the year.

• If you look at the uninsured in any given month, only 54.2 percent are working full time or are the dependent of a full time worker. In any given month, about 45.8 percent have no connection to employment.

Figure 7

Uninsured Persons by Relation to Employment (in thousands)



Source: Lewin Group estimates based upon the 1998 Current Population Survey (CPS) data corrected for underreporting and adjusted for the expansion of children's coverage under CHIP using the Lewin Group Medicaid Eligibility Simulation Model (MedSim).

INCREASES IN THE EMPLOYEE PREMIUM CONTRIBUTIONS SEEM TO BE PART OF THE PROBLEM

• The average percentage of the premium paid by the worker for single coverage increased from 13.0 percent in 1991 to 22.0 percent in 1996 (*Figure 8*). For family coverage it increased from 23.0 percent in 1991 to 31.2 percent in 1996.

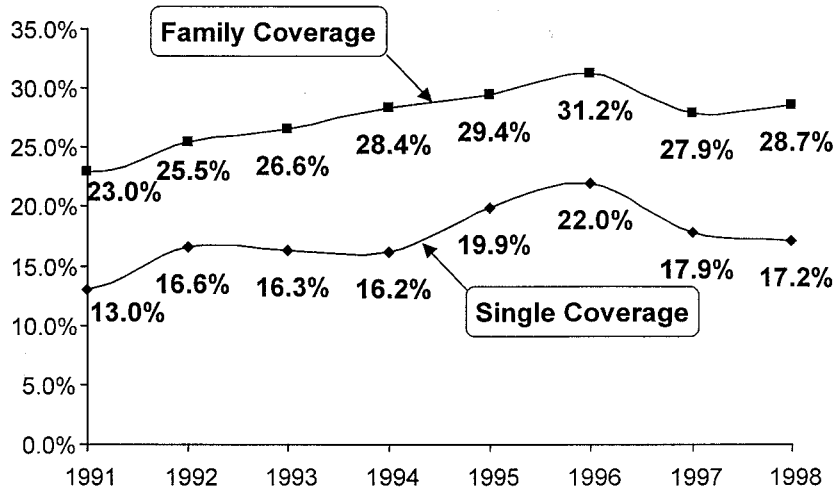
• A recent Lewin study showed that a 1.0 percent real increase (i.e., inflation adjusted) in premium prices results in 300,000 fewer persons taking employer coverage.[1]

[1] Sheils, John, Hogan, Paul, and Manolov, Nikolay, "Exploring the Determinants of Employer Health Insurance Coverage," (Report to the AFL–CIO) The Lewin Group, Washington, DC, January 20, 1998.

• Recent survey data also indicates that the percentage of individuals accepting the employer coverage available to them declined from 88.3 percent in 1987 to 80.1 percent in 1996.[2]

Figure 8

Percentage of Premium Paid by Workers in Employer-Sponsored Plans for Single and Family Coverage 1991 to 1998



Source: Based upon KPMG Peat Marwick data.

TROUBLING FINDINGS

• The uninsured population is growing by an average of 1.0 million persons per year.
• About 13.4 percent of the uninsured (4.8 million) will actually be eligible for Medicaid or CHIP but will not enroll.
• About 10.2 million of the uninsured (28.5 percent) could take coverage through an employer plan but have declined.
• Nearly 20 percent of the uninsured have family incomes in excess of $50,000 per year yet do not purchase health insurance.

Chairman THOMAS. Thank you very much, Mr. Sheils.
Mr. Holahan.

STATEMENT OF JOHN HOLAHAN, DIRECTOR, HEALTH POLICY CENTER, URBAN INSTITUTE

Mr. HOLAHAN. Thank you. Thank you for your invitation to discuss the problem of the uninsured. I am the director of the Health Policy Research Center at the Urban Institute.

This is a very large topic. I would like to make three points and the first relates to differences in insurance coverage between adults and children. In this country, we have made a very large effort over the last 10 to 15 years to expand coverage of children through Medicaid and, more recently, through the Children's Health Insurance Program. The result is that now children are more likely to

[2] Cooper, Philip and Steinberg-Schone, Barbara, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, Nov-Dec 1997, 16(6): 142–9.

be covered by Medicaid and much less likely to be uninsured than adults.

Figure one in my testimony shows differences between adults and children. The upper panel shows that the uninsured rates for adults are 17 percent versus the 12 percent for children. The lower panel looks at the population below 200 percent of poverty. There the difference is a 37 percent versus 21 percent. Adults are also much less likely to have a usual source of care and much more likely to be in fair or poor health than children.

I would also point out that these differences are likely to become greater. Children on Medicaid are less affected by welfare reform and they will also benefit from CHIP. Adults have fewer ways to stay on Medicaid after welfare reform and are more likely to become uninsured. I would conclude that these differences are likely to become greater.

The second point is about variations among States in uninsured rates. I am going to talk about data from the National Survey of American Families, a new survey that we have done at the Urban Institute. The survey has large samples at the State level for 13 States which allows us better estimates at the State level than does the Current Population Survey. It shows very large variations among States in private coverage, particularly in employer-sponsored coverage, and these variations in employer coverage strongly affect uninsured rates among States.

I point you to figure two in the testimony, which shows variations across States. Across the top are the percentage uninsured; the middle bar, the percentage covered by public programs; and the lower bar, population covered by private coverage, principally employer-sponsored coverage. There you can see that as employer-sponsored coverage goes down, the percentage uninsured tends to go up. It varies from a high in terms of private coverage from 84 percent in Wisconsin to 80 percent in Minnesota down to 58 percent in Mississippi to 56 percent in Texas. The corresponding uninsured rates are 5 percent in Minnesota and 6 percent in Wisconsin versus 19 percent in Mississippi and 21 percent in Texas.

This is not meant as a criticism of employers, but to point out that States have a much bigger problem to deal with where employer coverage is low. For example, if you look at that same chart, you can see that 16 percent of the population covered are not covered by private plans in Wisconsin versus 44 percent in Texas, giving States like Texas and their localities a much bigger problem to deal with than do others.

Figure four shows the same information for adults, that is, adults between 18 and 64 years of age. There you can see the pattern of variations in employer coverage as well as the mirror image in terms of variations in the uninsured rate. The coverage through private plans is 86 percent in Wisconsin down to 66 percent in Texas and the uninsured rate varies from 10 percent in Wisconsin to 27 percent in Texas.

I then want to move on and make a couple of points about recent insurance trends and this will sound a bit like what Paul Fronstin just said. The number of Americans without health insurance according to the Current Population Survey, has risen from 34.9 million in 1989 to 43.1 in 1997. The key thing here is that the reasons

for the growth before and after 1984 have changed. From 1989 to 1993, employer-sponsored coverage declined primarily for dependents. Medicaid grew sharply because of the expansions for children and pregnant women and the recession. And the uninsured rate grew, but not as much as it would have if it hadn't been for public sector growth.

Since 1994, employer-sponsored coverage grew significantly for both workers and dependents. The decline in Medicaid enrollment is probably the major reason for the increase in the uninsured. There have also been declines in private nongroup coverage for those below 200 percent of poverty. The uninsured continued to rise, but not as much as it would have risen had employer-sponsored coverage not continued to increase.

It is hard to know at this point whether this growth in the last few years in employer-sponsored coverage is the reversal of past trends—the product of a lower rate of growth in health care costs coupled with a tight labor market. But if employer-sponsored coverage turned around and started to fall at the same time that Medicaid rates were falling, then you could see a sharp increase in the uninsured.

Thank you very much.

[The prepared statement and attachments follow:]

Statement of John Holahan, Director, Health Policy Center, Urban Institute

Thank you for the invitation to address the Committee about the problem of the uninsured. In my testimony I will focus on three aspects: differences between adults and children, differences among states, and recent trends. There are three major conclusions:

(1) The United States has made a large effort to expand health insurance coverage of low-income children through the Medicaid program. This has continued more recently with the Children's Health Insurance Program. Largely as a result of Medicaid, children are much less likely to be uninsured than adults. Three-quarters of the uninsured in the United States are adults, and 37 percent of adults with incomes less than 200 percent of the Federal Poverty Line (FPL) are uninsured.

(2) There are significant differences among states in the likelihood of being uninsured. For both adults and children, the proportion of a state's population that lacks health insurance is inversely related to private coverage, predominantly provided through employer-sponsored plans. Medicaid and other state programs offset differences in private coverage to some degree. However, the problems states face in terms of the size of their uninsured populations depend largely on the extent of employer coverage.

(3) The decline in employer-sponsored coverage over the last 15 years has been well documented. This decline has resulted in increases in the number of uninsured, despite expansions of Medicaid. Since 1994, employer-sponsored coverage has actually increased, particularly for dependents. The number of uninsured has continued to increase, but now the major reason has been a decline in Medicaid enrollment.

This testimony draws on research that we have conducted at the Urban Institute. It relies on data collected through the National Survey of America's Families (NSAF), a new survey that provides information on over 100,000 children and nonaged adults representing the noninstitutionalized civilian population under age 65.[1] The NSAF, conducted from February to November 1997, was designed to provide both state representative estimates in 13 states as well as reliable national level estimates. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The testimony also relies on analysis of several years of Current Population Survey data.

Adults and children. Figure 1 provides data on rates of uninsurance, health status, and usual sources of care.[2] The upper panel shows that adults are much more likely to be uninsured than children; they are also more likely to be in fair or poor health and to lack a usual source of care than children. For families of all incomes, 17 percent of adults are uninsured compared to 12 percent of children. Adults are

also three times more likely to lack a usual source of care (18 percent versus 6 percent) and more than twice as likely to be in fair or poor health (12 percent versus 5 percent).

Both adults and children are worse off within low-income families, but the relative differences between adults and children are similar to those for all families. The lower panel of Figure 1 shows that uninsurance rates were 21 percent for low-income children and 37 percent for low-income adults. Health status was worse for low-income adults—23 percent of low-income adults were in fair or poor health versus 8 percent of low-income children—and they were less likely to have a usual source of care—27 percent of low-income adults versus 10 percent of children lacked a usual source of care. The finding that low-income adults are less likely to have a usual source of care is consistent with their being more likely to lack health insurance, but somewhat inconsistent with the fact that they are in poorer health.

Table 1 examines the insurance coverage of adults and children in more detail. The data show that, for families of all incomes, adults are slightly more likely than children to have private coverage, 75 percent versus 69 percent. However, they are much less likely to be covered through public programs (primarily Medicaid), 8 percent versus 20 percent. This results in a lower uninsurance rate for children than for adults.

Most of the differences between adults and children are because of different insurance arrangements of those below 200 percent of the FPL. Low-income adults are only slightly more likely to have private coverage than children, 44 percent versus 40 percent. However, low-income children are far more likely to have public coverage, 39 percent versus 20 percent, because of the poverty-related Medicaid expansions and because several states have other programs to subsidize health insurance for low-income children. The result of the more extensive public coverage of children is that the uninsurance rates for low-income children are substantially below those of low-income adults.

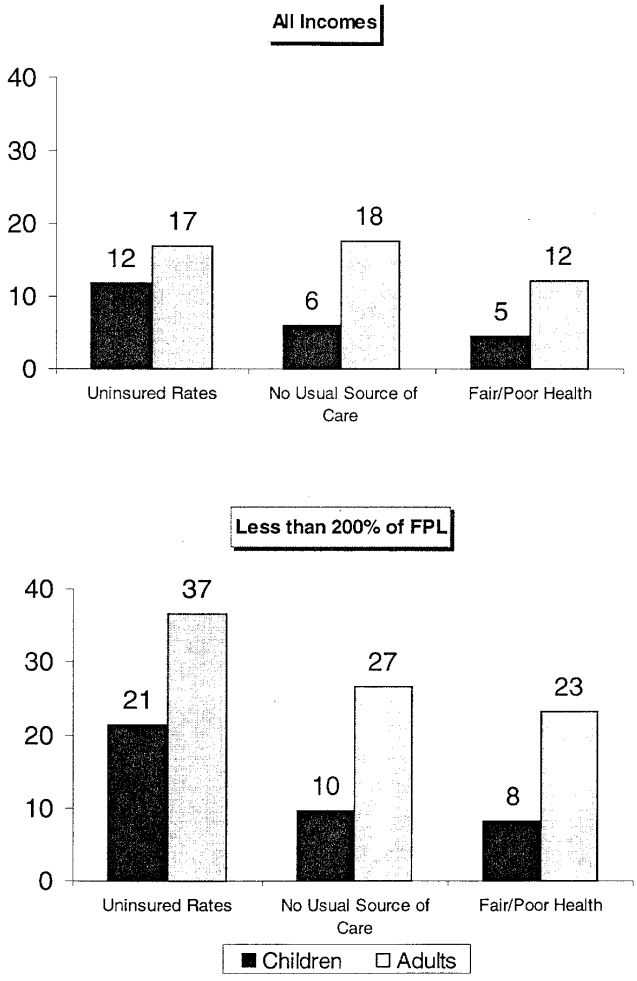
Variations among states in health insurance coverage: Children. State differences in health insurance coverage of children are shown in Figure 2. Private coverage (employer-sponsored and privately purchased insurance) for children of all incomes varies from a low of 56–58 percent (Mississippi, Texas) to a high of 84 percent (Wisconsin). Public coverage also varies from a high of 23–26 percent (California, Mississippi, New York, Texas, and Washington) to a low of 10–15 percent (Colorado, Minnesota, New Jersey, and Wisconsin). Public coverage is high where there are ambitious public programs that provide coverage such as in California, New York, and Washington. Public coverage is also high where there is a large low-income population, such as Mississippi and Texas. The high levels of public coverage in California and New York reflect both broad coverage and large low-income populations. In general, high levels of public coverage do not offset low levels of private coverage, with the result that states such as Mississippi and Texas have the highest uninsurance rates. Because of their high rates of private coverage, states such as Massachusetts, Michigan, Minnesota, and Wisconsin have the lowest rates of uninsurance.

Data in Figure 3 show that public coverage has a greater impact among lower-income children than among all children. States with public programs that have had broad coverage expansions, e.g., Massachusetts and Washington, or where existing eligibility rules bring in large numbers of children because there are so many low-income families, e.g., California and New York, have the highest rates of public coverage. Public coverage does more to offset low private coverage among low-income children than for all children. For example, while New York and Washington have below-average rates of private coverage for low-income children, they have above-average rates of public coverage, and as a result, have below-average rates of uninsurance.

Public coverage, however, does not always offset low levels of private coverage. For example, Texas and Mississippi both have below-average levels of private coverage. Both have levels of public coverage that are not significantly different from the national average. As a result, they have uninsurance rates of 32 and 28 percent, respectively, that are well above the national average. Colorado has levels of private coverage of low-income children similar to the national average, but public coverage is considerably below average. The result is an uninsurance rate that is significantly higher than the national average. Finally, Massachusetts stands out as a state whose private coverage is equal to the national average, but that also has very high rates of public coverage. The result is one of the lowest rates of uninsurance of low-income children in the nation.

Figure 1

Insurance Coverage, Health Status and Lack of a Usual Source of Care: Adults and Children



Source: Urban Institute, National Survey of America's Families, 1997

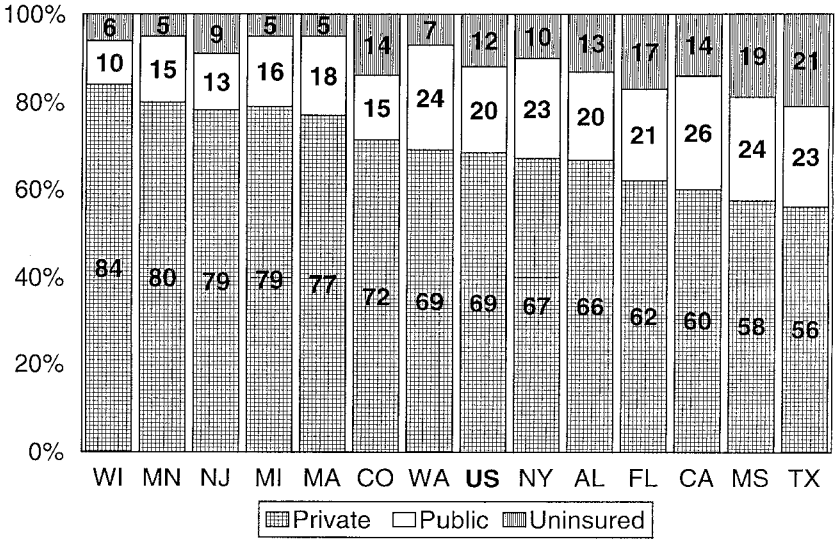
Table 1

Insurance Coverage of Adults and Children

	All Incomes		Below 200% Poverty	
	Adults	Children	Adults	Children
Private	75%	69%	44%	40%
Public	8%	20%	**20%**	**39%**
Uninsured	17%	12%	37%	21%

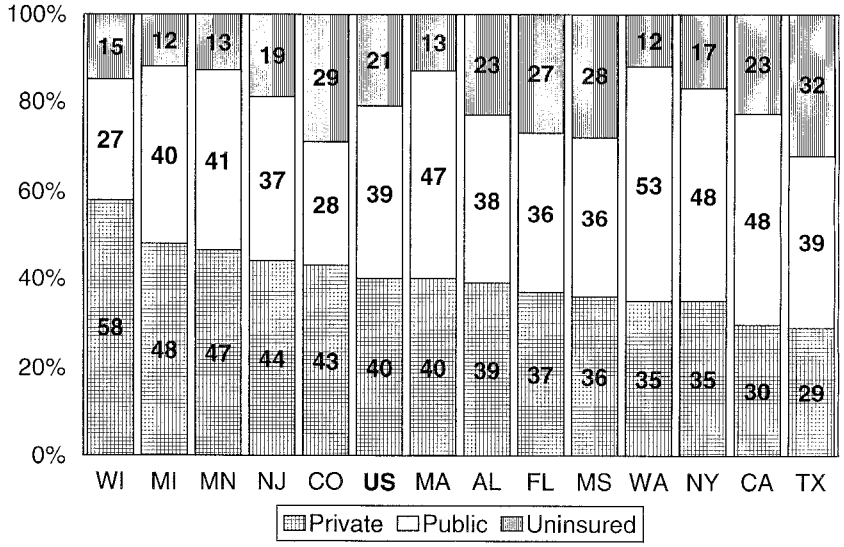
Source: Urban Institute, National Survey of America's Families, 1997

Figure 2: Health Insurance Coverage of Children Under 18, by State, 1997



Source: Urban Institute, National Survey of America's Families, 1997

Figure 3: Health Insurance Coverage of Low-Income Children Under 18, by State, 1997



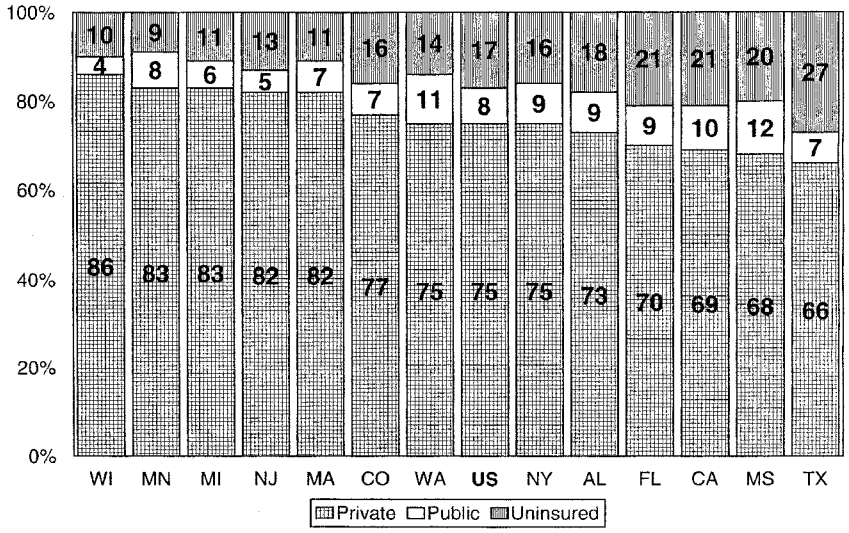
Source: Urban Institute, National Survey of America's Families, 1997

Some states with high rates of public coverage of low-income children still end up with relatively low rates of public coverage of children overall because they have relatively small low-income populations—for example, Massachusetts. The opposite is true for a state like Texas. For example, Texas covers 39 percent of its low-income population (less than Massachusetts, at 47 percent) but 23 percent of its entire child population (versus 18 percent in Massachusetts). Another interesting contrast is that of Minnesota and Mississippi. Minnesota covers 41 percent of its low-income population, but only 15 percent of its entire population. Mississippi, in contrast, covers 36 percent of its low-income population, about equal to the national average, but 24 percent of its entire population.

This suggests that it is both public policy and the size of the low-income population to which those policies are directed that will affect the proportion of children in a state covered by public programs. This explains why states such as Texas and Mississippi cover a higher proportion of their children through public programs than states such as Massachusetts and Minnesota, typically regarded as states with very generous policies.

Variations among states in health insurance coverage: Adults. A similar picture emerges for adults. Figure 4 shows that private coverage varies from 66–68 percent (California, Florida, Mississippi, and Texas) to 82–86 percent (Massachusetts, Michigan, Minnesota, and Wisconsin). Public coverage varies from 10 to 12 percent in California, Mississippi, and Washington to as low as 4 percent in Wisconsin and 5 percent in New Jersey. Public coverage does less to offset variations in private coverage among adults than among children. Thus, states such as California, Florida, Mississippi, and Texas have the highest rates of uninsurance (21–27 percent), while states such as Massachusetts, Michigan, Minnesota, and Wisconsin have the lowest rates of 9 to 11 percent. Because there is less variation in public coverage for adults than for children, the variation in uninsurance rates more closely tracks the variation in private coverage.

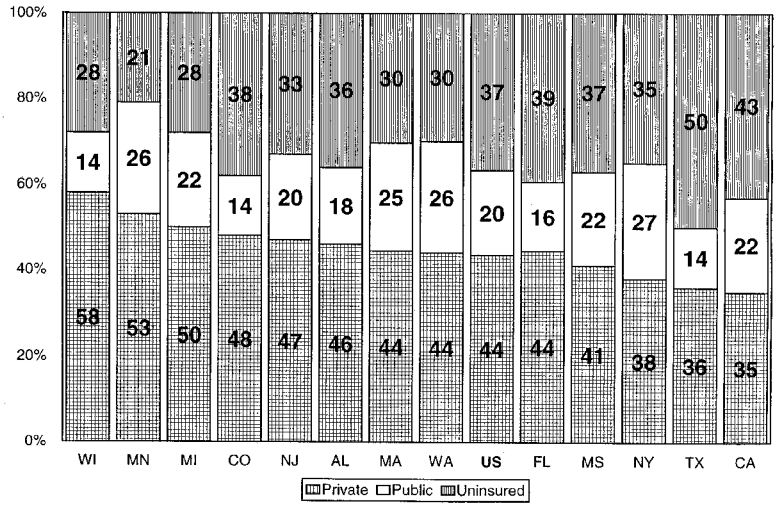
Figure 4: Health Insurance Coverage of Adults(18-64 Years of Age) by State, 1997



Source: Urban Institute, National Survey of America's Families, 1997

Public programs are, again, more important for low-income nonelderly adults than for all nonelderly adults. Figure 5 shows that states such as Massachusetts, Minnesota, New York, and Washington have the highest rates of coverage in public programs. But again, this public coverage usually does not offset the variations in private coverage. For example, California and Texas had very low rates of private coverage, 35 and 36 percent, respectively. California's 22 percent of low-income adults with public coverage and Texas's 14 percent did not offset these low rates of private coverage. Consequently, those states had higher-than-average uninsurance rates for low-income adults; 43 percent in California and 50 percent in Texas. In New York, a relatively high rate of public coverage, 27 percent, did offset the low rate of private coverage, giving New York an uninsurance rate close to the national average. An exception is Colorado, which had such a low rate of public coverage, 14 percent, that it had an uninsurance rate comparable to the national average despite having relatively high rates of private coverage.

Figure 5: Health Insurance Coverage of Low Income Adults (18-64 Years of Age) by State, 1997



Source: Urban Institute, National Survey of America's Families, 1997

As was observed for children, some states typically thought of as having very generous public programs actually have below-average rates of public coverage for adults as a whole. For example, Massachusetts, which had above-average coverage of the low-income adult population, had slightly below-average coverage of the adult population as a whole. This is because Massachusetts has a relatively small low-income adult population. At the other extreme, Mississippi and California, which have about average coverage of the low-income adult population, have above-average coverage of the adult population as a whole because of their large low-income populations.

Why does the number of uninsured continue to grow? The number of uninsured in the United States has continued to increase, but for different reasons in the past few years (1994–1997) than in the prior period (1989–1993). Table 2 provides information on coverage for all nonelderly and for adults and children; Table 3 provides information on coverage for individuals in households with incomes below 200 percent of the FPL, between 200 and 399 percent of the FPL, and at or above 400 percent of the FPL. The tables show the number of individuals by type of coverage in 1989–93 and 1994–97, as well the average annual growth rates.

The reason for the break between 1993 and 1994 is that major changes were made to the Current Population Survey that make comparisons of trends before and after inappropriate. The years 1993–94 are an important breakpoint for other reasons as well. About this time, the economy had emerged from the 1990–92 recession and began a long period of economic growth. In addition, the Medicaid expansions to coverage children and pregnant women had been phased in, and state welfare reform efforts began to affect Medicaid enrollment.

Table 2 shows that the number of uninsured increased by 6.6 million (4.4 percent annually) between 1989 and 1993. The number of uninsured children and adults increased by 1.3 and 5.3 million, respectively (2.7 and 5.1 percent annually). For both children and adults, there were declines in employer-sponsored coverage, particularly for dependents. The Medicaid expansions partially offset the declines in employer-sponsored coverage for both groups.

Table 2.—Health Insurance Coverage, 1989–1997 Nonelderly by Age Group

Type of Coverage [1]	Millions				Average Annual Growth	
	1989	1993	1994	1997	1989–93	1994–97
All Nonelderly:	215.7	228.0	229.9	236.2	1.4%	0.9%
Employer (own) [2]	71.3	72.2	75.1	77.4	0.3%	1.0%
Employer (other) [3]	70.8	65.9	72.9	76.4	−1.8%	1.6%
Medicaid	15.1	22.9	23.0	21.1	10.9%	−2.9%
Other Public [4]	7.0	7.7	6.1	5.7	2.3%	−2.6%
Other Private [5]	16.5	17.9	13.2	12.6	2.0%	−1.6%
Uninsured [6]	34.9	41.5	39.6	43.1	4.4%	2.9%
Children: 0–18	67.9	73.2	74.0	75.5	1.9%	0.7%
Employer (own)	0.2	0.4	0.6	0.4	23.8%	−11.3%
Employer (other)	42.4	41.0	44.3	46.6	−0.8%	1.7%
Medicaid	7.8	12.3	13.3	12.1	12.1%	−3.1%
Other Public	2.8	3.5	1.7	1.5	6.0%	−3.7%
Other Private	3.6	3.5	3.3	3.2	−0.9%	−1.5%
Uninsured	11.1	12.4	10.7	11.6	2.7%	2.8%
Adults: 19–64	147.8	154.9	155.9	160.7	1.2%	1.0%
Employer (own)	71.1	71.8	74.5	77.0	0.2%	1.1%
Employer (other)	28.5	24.9	28.6	29.8	−3.3%	1.3%
Medicaid	7.3	10.6	9.6	8.9	9.7%	−2.5%
Other Public	4.2	4.1	4.4	4.1	−0.3%	−2.2%
Other Private	12.9	14.4	9.8	9.4	2.7%	−1.6%
Uninsured	23.8	29.1	29.0	31.5	5.1%	2.9%

Source: Urban Institute, 1999. Based on data from March Current Population Surveys, 1990–1998.
Note: Excludes persons aged 65 and older and those in the Armed Forces.
Starting with the 1995 March CPS, significant changes were made to the questionnaire regarding health insurance coverage, including changes in question order, the use of state-specific Medicaid program names, and the addition of more detailed questions. In addition, the 1995 CPS reflects a change in the questionnaire's sample framework. Therefore, it is recommended that data from 1994 and afterwards not be compared to data from previous years in time-series analyses.
[1] Although survey respondents can choose more than one type of health insurance coverage, individuals were assigned one type of coverage, following a hierarchy as listed.
[2] Insurance through an individual's own employer group health plan
[3] Primary coverage through another worker's employer group health plan (i.e., spouse or parent's plan).
[4] Coverage from other non-Medicaid government insurance programs (i.e., Civilian Health and Medical Program of the Uniformed Services [CHAMPUS], Medicare, etc.).
[5] Coverage through a private insurance plan, but not as part of an employer-provided benefit (i.e., individually purchased nongroup coverage).
[6] Uninsured is the residual category. An individual is classified as uninsured if he or she did not report any of the previous types of insurance coverage over the course of the year. Those with Indian Health Services as their only source of insurance are considered uninsured.

During the 1994–1997 period, the number of nonelderly uninsured increased by 3.5 million (2.9 percent annually), while the number of uninsured children and adults increased by 0.9 and 2.6 million, respectively (2.8 and 2.9 percent annually). But the increases in the uninsured in the latter period occurred for different reasons. First, there was a drop in Medicaid of about 1.9 million people (1.2 million children and 0.7 million adults, or 3.1 and 2.5 percent annually, respectively). There were also decreases in other public coverage of 0.4 million; this was due principally to reductions in military-related coverage (e.g., CHAMPUS, Veterans' Administration) presumably due to military downsizing. There was also a reduction of 0.6 million in other private coverage, possibly reflecting the increased cost of health insurance in the private nongroup market.

These reductions in Medicaid, other public and other private coverage would have resulted in even greater increases in the uninsured had it not been for increases in employer-sponsored coverage. The number of adults covered through their own employers increased by about 2.5 million or by 1.1 percent annually, while the number of dependent children covered increased by 2.3 million or 1.7 percent annually and the number of dependent adults increased by 1.2 million or 1.3 percent annually. Thus, unlike the previous period, the increase in employer coverage kept the number of uninsured from increasing by more than it otherwise would have.

Table 3 provides similar data, disaggregated by income category. For those below 200 percent of the FPL, there was a large increase in Medicaid enrollment (7.4 million or 10.7 percent annually) between 1989 and 1993. There were also smaller increases in employer-sponsored coverage as well as other public and other private coverage. But because of a large increase in size of the population below 200 percent of the FPL, the number of uninsured increased by 3.8 million (3.6 percent annually).

Between 1994 and 1997, there were large reductions in Medicaid enrollment (about 2.0 million), in other public coverage (0.4 million), and in private nongroup coverage (1.1 million). Because of these declines, the number of uninsured increased by 1.3 million. The increases would have been larger had it not been for the strong economy reducing the number of people below 200 percent of the FPL.

Table 3.—Health Insurance Coverage, 1989–1997 Nonelderly by Income

Type of Coverage [1]	Millions				Average Annual Growth	
	1989	1993	1994	1997	1989–93	1994–97
All Nonelderly:	215.7	228.0	229.9	236.2	1.4%	0.9%
Employer (own) [2]	71.3	72.2	75.1	77.4	0.3%	1.0%
Employer (other) [3]	70.8	65.9	72.9	76.4	−1.8%	1.6%
Medicaid	15.1	22.9	23.0	21.1	10.9%	−2.9%
Other Public [4]	7.0	7.7	6.1	5.7	2.3%	−2.6%
Other Private [5]	16.5	17.9	13.2	12.6	2.0%	−1.6%
Uninsured [6]	34.9	41.5	39.6	43.1	4.4%	2.9%
Less than 200%:	74.4	88.2	87.6	85.1	4.3%	−1.0%
Employer (own)	10.2	11.6	12.4	12.1	3.4%	−0.9%
Employer (other)	14.3	13.9	16.1	16.0	−0.8%	−0.1%
Medicaid	14.5	21.9	21.8	19.8	10.7%	−3.1%
Other Public	4.0	4.9	3.5	3.1	5.3%	−4.6%
Other Private	6.8	7.6	6.0	4.9	2.7%	−6.2%
Uninsured	24.5	28.3	27.8	29.1	3.6%	1.6%
200 to 399%:	72.2	71.9	71.6	73.0	−0.1%	0.6%
Employer (own)	27.1	27.5	27.5	27.4	0.4%	−0.2%
Employer (other)	30.0	27.0	28.7	29.3	−2.6%	0.7%
Medicaid	0.5	0.9	0.9	1.0	17.8%	1.1%
Other Public	1.9	1.7	1.7	1.7	−2.7%	−1.7%
Other Private	5.3	5.5	4.1	4.0	1.0%	−0.7%
Uninsured	7.4	9.2	8.6	9.7	5.5%	4.1%
400 and over:	69.1	68.0	70.7	78.1	−0.4%	3.4%
Employer (own)	34.0	33.0	35.2	38.0	−0.8%	2.6%
Employer(other)	26.5	25.0	28.1	31.1	−1.4%	3.4%
Medicaid	0.1	0.1	0.2	0.3	6.1%	3.0%
Other Public	1.1	1.0	0.8	0.9	−0.9%	3.3%
Other Private	4.4	4.8	3.1	3.6	1.9%	5.2%
Uninsured	3.0	4.0	3.2	4.3	7.7%	9.7%

Source: Urban Institute, 1999. Based on data from March Current Population Surveys, 1990–1998.
Note: Excludes persons aged 65 and older and those in the Armed Forces.
Starting with the 1995 March CPS, significant changes were made to the questionnaire regarding health insurance coverage, including changes in question order, the use of state-specific Medicaid program names, and the addition of more detailed questions. In addition, the 1995 CPS reflects a change in the questionnaire's sample framework. Therefore, it is recommended that data from 1994 and afterwards not be compared to data from previous years in time-series analyses.
[1] Although survey respondents can choose more than one type of health insurance coverage, individuals were assigned one type of coverage, following a hierarchy as listed.
[2] Employer (own) coverage includes insurance through an individual's own employer group health plan.
[3] Employer (other) is primary coverage through another worker's employer group health plan (i.e., spouse or parent's plan)
[4] Other Public is coverage from other non-Medicaid government insurance programs (i.e., Civilian Health and Medical Program of the Uniformed Services [CHAMPUS], Medicare, etc.).
[5] Other Private is coverage through a private insurance plan, but not as part of an employer-provided benefit (i.e., individually purchased nongroup coverage).
[6] Uninsured is the residual category. An individual is classified as uninsured if he or she did not report any of the previous types of insurance coverage over the course of the year. Those with Indian Health Services as their only source of insurance are considered uninsured.

For those at the other end of the income distribution, i.e., 400 percent of the FPL and over, Medicaid and other public programs are relatively unimportant. This income group experienced a reduction in employer-sponsored coverage between 1989 and 1993, and as a result the number of uninsured increased by 1.0 million, or 7.7 percent annually. Between 1994 and 1997 the number of uninsured continued to increase, again by 1.1 million or 9.7 percent annually. In this period there were significant increases in employer-sponsored coverage and in nongroup coverage, but these were not sufficient to match the substantial population growth in this income range.

In sum, these results mean that between 1994 and 1997 low-income populations were adversely affected by significant reductions in Medicaid (2.0 million) and not

helped by the increase in employer coverage. They also experienced substantial drops in private nongroup coverage. The number of uninsured among families with incomes below 200 percent of poverty increased by 1.3 million. Had it not been for a decline of 2.5 million in the total number of people below 200 percent of the FPL, the increase in the number of low-income people who were uninsured would have been much higher. For higher-income adults and children, the increases in employer coverage and in private nongroup coverage were substantial, but not sufficient to keep up with the growth in the number of higher-income adults and children, resulting in an increased in the uninsured of 1.1 million, or 9.7 percent annually.

ENDNOTES

[1] Stephen Zuckerman, Niall Brennan, John Holahan, Genevieve Kenney, and Shruti Rajan, "Snapshots of America's Families: Variations in Health Care Across States," Washington, DC: The Urban Institute (Assessing the New Federalism), February 1999.

[2] The information presented in this testimony shows a lower percentage of children and nonelderly adults being uninsured than reported in the Current Population Survey. There are two fundamental reasons for the differences between the two surveys and their measures of insurance coverage. The first reason is that the NSAF measures insurance coverage at the time of the survey, whereas the CPS asks about coverage during the previous calendar year. The second reason for the difference is that the CPS asks a series of questions about insurance coverage and then assumes that any person not designated as being covered through any type of health is uninsured. The NSAF uses a series of questions similar in wording and sequence to the CPS, but adds a question that verifies whether people who appear not to have coverage are, in fact, uninsured. A substantial number of people who are initially designated as uninsured change to being insured as a result of the verification question. A detailed discussion of this issues is presented in Zuckerman, et al. (1999).

The views expressed in this statement are solely those of the author and should not be attributed to the Urban Institute, its trustees or its funders.

Chairman THOMAS. Thank you very much. I think everyone agrees that at least, notwithstanding Dr. Fronstin's suggested adjustments to the 43 million where there may be some overcounts—I believe it was your testimony; it is somewhere between—oh, no, it was Mr. Sheils—it is somewhere between 38 and 43 million.

But when we begin to address the group in terms of potential public policy response, there are just a couple of percentages that jumped out at me. For example, somebody had a chart which showed that 19.8 percent over $50,000 were uninsured. And at some point, you begin asking yourself the question are these people comfortable, depending upon how many are in the higher income brackets, being, in essence, self-insured, that they don't think the purchase of insurance, as they see it, as an economic value worth spending the money? Or what is it that clearly creates a decision on someone who is making maybe even $100,000 a year not to have health insurance?

Those questions and the pursuit of that I think would be fundamentally different than when you say 13.4 percent of those who are eligible for Medicaid or CHIP are not now covered by a program in which they are eligible to be covered. Why aren't those people—why don't we have an outreach program? And, if we do, why is it not successful? It just seems to me, in addressing the question of insured, there are two fundamentally different approaches to two different groups.

And if you have got more than 11 percent who have chosen not to take the health coverage and, notwithstanding the fact that their employer offers it, then that is another group that we could deal with, perhaps, in a slightly different way.

That kind of a profile leads me to the question, I guess, that my friend from California thinks we already have the answer to, is there a single thing that would have the biggest impact on the uninsured? If we could do one thing or if were going to try to prioritize, in terms of public policy, where would we get the best return on our investment of trying to reduce the number of uninsured? Notwithstanding the fact that apparently there are some who, whatever we would do, would probably not be interested unless it was a mandated program to require them to carry health insurance because it appears not to be a financially driven decision. What is it that would be the one thing that we could do that would have the greatest impact? Any of the panelists.

Ms. ARNETT. Mr. Chairman——

Mr. FRONSTIN. Can I just clarify one thing about the income estimates?

Chairman THOMAS. Surely.

Mr. FRONSTIN. I think when you are looking at a person who reports they are in a family that has an income of $50,000—say, $50,000, $60,000—my guess is you could easily find that a lot of those people are in two-worker families. Each worker is maybe making half that amount, $25,000 or $30,000. And they are less likely to be offered coverage to begin with because of the job they have, not because of the family income, when you look at it in aggregate.

Chairman THOMAS. I think that is a fair enough statement. And let us remove a significant percentage of those. I think when you begin whittling it down, you are still going to find what it would be, I think, a surprising percentage, even if it is only 5 or 6 percent, of people who are counted in the groups of the uninsured who would meet an income profile significantly different than most people just a priori thinking what the uninsured look like.

Mr. FRONSTIN. True.

Chairman THOMAS. Thank you.

Mr. FRONSTIN. And, in terms of where you would have the biggest effects, if you take the uninsured pie, 43 million, and start dividing it up, you really have 2 major groups. Workers in small firms and their dependents account for about 60 percent, and that includes self-employed, 98 percent of which work for small firms. And my definition of small firms is 100 or fewer than 100 employees. That is over half.

The other large piece of that pie is children. We are talking about 25 percent of the uninsured. While there is now a CHIP, that will have some impact on that population. If the estimate is that only 2 million children will be covered under that program, that still leaves 8 or 9 million children uninsured.

I think that is where you will have the biggest effect. I don't think you are going to have a big effect with the near-elderly, the 55- to 64-year-olds. There are about 3 million uninsured in that population. If, by chance, we got every single one of them covered, whether it be a Medicare Program or something else, you still have 40 million people uninsured. It won't have a big effect on the total picture, but it will certainly have an effect for that population.

Chairman THOMAS. Well, if we are concerned about access to and affordability of health insurance, based on what you just said, it

sounds to me like trying to help buy down the cost of participation would be a major factor in picking up that single largest group that you identified.

Mr. FRONSTIN. Cost is the major reason, but also, when you are looking at small employers, it is not just cost. Small employers are typically more concerned about running the day-to-day operation of their business than they are about going out and searching for health insurance, even at a reasonable cost. And a lot of small employers would like to do that, but they just don't have the time; they don't have the staff or the resources.

Ms. ARNETT. Mr. Chairman, I believe that the direct correlation between rising costs and the rising number of uninsured shows that an important step is to provide resources to help people to purchase health insurance. I think that is why there has been so much interest in the individual tax credit proposals Mr. McDermott has introduced. I know you and Mr. McCrery are working on a tax credit proposal. I know Mrs. Johnson has expressed interest and others as well in individually based tax credits. This idea has strong support in the market-based policy community.

My colleague, Mark Pauly, a professor of health economics from the Wharton School, is doing an analysis now which is not yet published but will soon be. His research shows that if Congress were to provide a tax credit worth half the value of a decent health insurance policy, that the number of uninsured workers would fall by half, which is really a significant number. The costs numbers may be unaffordable, but I think it points in the right direction. The chart on my right shows where the problem really is. If people are of very low income, they very likely qualify for public programs. As they move up the income scale, they fall out of public programs but yet don't make enough to qualify for the generous taxpayer support for employment-based health insurance.

If something can be done to help people in the $20,000 to $40,000 income range who are not eligible for public programs and don't qualify for or benefit from the employment-based exclusion, that would help enormously.

Chairman THOMAS. Does anyone else want to comment?

Mr. SHEILS. Yes. I just wanted to make a point that we have looked at tax credits. Tax credits are interesting. There are a lot of nice ideas there and there are a lot of things where you can get lost.

One idea is to assist workers who have employer-based coverage in buying that coverage, giving them a tax credit, for example, for them to purchase some of that coverage. They are basically adding the employer's contribution to their own, or to the tax credit, and they can purchase it. The problem with that is that if you made the credit generally available to all workers, you would find that about three-quarters of the money that you were going to spend is going to go to people who already have insurance.

Chairman THOMAS. Exactly, or higher.

Mr. SHEILS. That is true. Also it is important not to leave out the nonworker category. This is a group of people who often are not working because they can't work. Some measure of disability, for example, is an example. We would not want—I am not sure we

would want to focus a credit just on, say, the workers. The nonworker group probably deserves its attention as well.

We have looked at some of these proposals where a tax credit was provided generally to all individuals for up to half of the premium. We saw the number of uninsured would be reduced by between 8 and 10 million persons. That would be a very big drop in the number of uninsured. It wouldn't be quite as much as half of the uninsured, but it would be quite significant.

Chairman THOMAS. Mr. Holahan.

Mr. HOLAHAN. Yes. Could I just make a point? A couple of points. One is that the numbers of people who would take up insurance with a 50-percent subsidy sound a bit high to me. I would like to know more about where that came from. Because I think, even for low-income people, subsidies closer to 100 percent result in participation rates in the 50- to 60-percent range. And as subsidies decline as incomes go up, you would see lower takeup rates.

Which goes to a related point that it is just remarkable, not just for low-income people, but for high-income people, why people don't value health insurance more than they do. You hear people say I won't need it or I'm healthy, but the point about insurance is to have it in those rare times when you really do have a very costly episode. I think a lot of education has to go on at all income levels to make people understand what insurance is all about because it is not just low-income people that don't take advantage of subsidies.

Chairman THOMAS. And, before I call on my colleague, that leads to what I think is one of the other concerns and this Subcommittee doesn't have as much of a jurisdictional opportunity as we would like in fully discussing the issue. Because it doesn't make sense to talk about health insurance just for the workers and it doesn't make any sense to have a tax credit structured, in my opinion, the way it is, through the employers for those workers.

But your statement, Mr. Holahan, addresses the fact that it doesn't make a whole lot of sense to me either to have the cheapest group insurance concept go to the group that can get up every morning and go to work and get a tax benefit as well and the most expensive insurance, those who can't work and who have the biggest problems in the individual market. The whole concept of the way we deal with insurance and package it available to people and its relationship to the Tax Code, in my opinion, is all flawed. And that when you begin looking at how you want to solve the problem, it rapidly gets beyond simply putting some money out there for people to buy a product, in my opinion.

The gentleman from California.

Mr. STARK. Thank you, Mr. Chairman. Ms. Arnett, I was curious and did a little research. This guy Galen was quite a fellow. He was involved in socialized medicine all of his career as a physician. He was a doctor to a bunch of emperors and gladiators. He was nutty as a fruitcake. As one biographer put it, he made critical errors that remained unchallenged for 1,400 years—sort of like the Republican Party. He became the ultimate medical authority for the ascendant Christian church and now the guiding light of the Bob Jones' medical school, Bob Jones' University.

But, aside from that, your testimony does need some correcting, no matter who Galen is. You testified that surveys conducted by the NFIB show that the majority of small business owners would like to offer health insurance, but the costs make it prohibitive. That is not correct. An NFIB survey—and I will ask consent to put this in the record——

Chairman THOMAS. Without objection.

[The information follows:]

Questions:		Results in percent: Your District (09)	Your State (CA)	The Nation
1. Should the winner in a lawsuit be able to collect legal fees from the loser?	Favored :	80	75	72
	Opposed :	13	15	17
	Undecided:	7	10	11
2. Should employers be required to offer health insurance without having to pay the premiums?	Favored :	27	30	29
	Opposed :	58	59	60
	Undecided:	15	11	11
3. Should employees be tested for illegal drugs after a workplace accident in which an injury or death occurs?	Favored :	81	78	78
	Opposed :	14	13	12
	Undecided:	5	9	10
4. Should individuals below the age of 18 be required to obtain work permits?	Favored :	20	24	20
	Opposed :	75	69	72
	Undecided:	5	7	8
5. Should business owners be eligible to receive unemployment insurance benefits?	Favored :	63	61	60
	Opposed :	24	26	27
	Undecided:	13	13	13

Mr. STARK [continuing]. Done by the NFIB shows that to be inaccurate. The question was: Should employers be required to offer health insurance without having to pay the premiums? Sixty percent to seventy percent of the employers said no, even at no cost to them. What you are really finding is the NFIB's members wouldn't offer health insurance if it was free. I think you should review your testimony there.

And in your testimony, you cite other sources that did studies for lobbying groups. You cite the Urban Institute study in support of your position. Well, we called Len Nichols, the author of the report, and he disagreed. He said that the great preponderance of independent academic research shows that, on balance, insurance reform has not affected coverage. Some helps, some hurts. But, in general, it has helped people who need insurance get it and caused some people who didn't particularly need it to drop the coverage. Not a bad social outcome, as the Urban Institute researcher, Mr. Nichols, said. You should take that reference out of your speeches because they don't stand with you on that issue.

We have also heard some of the questions of the problem of people who don't sign up for insurance. And I suspect that, if insurance is mandated or made generally available through a tax credit or some other source, that many uninsured will not choose to sign up. I don't believe they choose not to, I think a lot of them are unaware. The outreach programs are bad. There is a whole host of

problems. For example, the CHIP doesn't work very well. But, when they get to an emergency room, I would be willing to bet you that 90 out of 100 hospitals don't let them get past the admissions desk if they qualify for some sort of coverage.

So that, for the hospital or indeed the physician to be paid, at the point of entry into the care system, these people who would be eligible under any kind of a program that we might come up with. They will will almost be required to sign up at the point of admission. Those are the people who obviously need the coverage and we might save a little money by not covering them until they need it. I think that is not a good solution because arguably they should get treated before they get to an emergency room.

But the issue, it still seems, is that if we had everybody in this country covered, all the questions of who are the uninsured would be moot. There wouldn't be any. There aren't any in Canada. You guys, if this was the only research you did, would be out of business if you lived in Canada. I like you all, but I would like to put you all out of business on this topic as soon as we can. Thank you, Mr. Chairman.

Mr. SHEILS. I am ready for retirement anyway.

Mr. STARK. I tell you, if we get universal health coverage, I will join you.

Chairman THOMAS. The gentlewoman from Connecticut. Are you leaving us as well? They are all leaving if they can get universal coverage, so it is really tempting to shift the topic. The gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. I have to stay to be sure they don't. [Laughter.]

First of all, that was a very interesting figure that my colleague from California quoted about the small business community's reluctance to provide health insurance even if they don't have to pay the premium. It is very interesting that in 1998, Hay Huggins' survey found that the overhead costs for firms with fewer than 10 employees were 35 percent compared to 12 percent compared to 12 percent for companies with over 500. It isn't just the premiums.

We found this in the Pension Reform Initiative, too. Only half of America's working people have even an option to pension plans because the administrative costs are so large for small companies that they can't afford to get into the business.

The administrative costs are an issue and increasingly, and particularly, I might add, under my colleagues from the other side of the aisle's Patient Protection Act, those very employers would be exposed to malpractice suits. That is another issue.

But they have every reason to be afraid that if they get into this, government regulation will cost them far outside the premiums in a way that many would not be able to survive.

I want to ask a different question, though. Of this 36 million figure, do any of you have—can you give us better guidance on how many of these people are uninsured for, say, less than 6 months? You know, how much of this problem is a transition problem and how much of it is a small business problem? And what insight can you give us as to that third of the companies with more than 500 employees that don't provide health insurance?

Mr. SHEILS. Well, I have a slide in here that I think will be helpful to you. It is on the number of individuals who are uninsured who are working. If you look at them on an average monthly basis—this would be on figure seven—on an average monthly basis, in any given month, about 37.9 percent of the uninsured are working full time and they have, about 16.3 percent, have dependents. So, together, the number of people who are connected to employment while uninsured, on a given month, will come to about 55 percent of the uninsured.

About 46 percent of the uninsured are what we call nonworkers. They are not working at the time and they are not a dependent of a worker. And those individuals, to address that population, you would have to have a fairly substantial program directed at nonworkers. Very often people look at these data and they say, well, a lot of the uninsured in the CPS were working. Seventy-five percent were either working or were the dependents. But, in fact, a lot of them were just working part of the year. When you look at it on an average monthly basis, in a given month, as you have asked your question, the problem is really split about 50–50 between workers and nonworkers.

Mrs. JOHNSON OF CONNECTICUT. And, in terms of the larger firms that don't provide insurance, my understanding is that two-thirds of the firms with over 500 employees provide insurance, some kind of health insurance, and one-third don't. What do you know about the one-third that don't? Because that certainly is a big enough pool.

Mr. SHEILS. I am more familiar with the figure of, I think, 25 percent. Seventy-five percent were offering it. But some of those firms are very large firms who are providing services. An example there is there is a major grocery chain that is now expanding throughout the country. It uses nonunion labor. There are no benefits to speak of. And those firms are coming in and crowding out some of those smaller chain stores in some areas where, in effect, you have coverage already. Some of this has to do with new phases in marketing with some of these firms, too. New ways to come in and introduce, frankly, cheaper labor into the marketplace to gain market share.

It is really a labor market issue out there. If the employer feels they have to offer insurance to get people signed up and working for them, they will offer it. If they don't, if the workers, low-wage workers in particular, they are probably more interested in the wages, first, rather than the health benefits themselves. It varies across individuals. But a lot depends on what the individual is looking for, the people in the labor force, are looking for in the way of employment.

Mrs. JOHNSON of Connecticut. And then, last, each of you have said a number of different things about what the impact would be of tax deductions and tax credits. First of all, I personally think it is a matter of fairness. We subsidize the access to insurance for everyone who gets it through employers. I think it is grossly unfair not to provide equal subsidies for those who don't.

In my bill that I am putting in this week, it has very rich subsidies because I am trying to make it comparable to the subsidy—not the tax benefit to the individual, which is far lower, if it were

converted into wages—but to the access to effectively free health insurance with copays that employees get through employers. And Ms. Arnett did quote some research that is in process, but I would appreciate your help in the coming days and any thoughts that you might have.

But if you gave a tax credit to the low-income people and a deduction to high-income people, which my bill does, equal to the benefit that people who work for employers and get health insurance through their employers, the impact would be as great on their lives as through employment, then I think we would have a much greater impact on including the uninsured or bringing the uninsured into the insured group. I would be interested in your thoughts on that.

My time has expired, but if you will get back to me on that, I would appreciate it.

[The following was subsequently received:]

TAX CREDIT ISSUES

The current tax code is often criticized as contributing to the uninsured population.[1] As a result, proposals to expand health insurance coverage through a tax credit have been receiving increased attention lately. The tax credits proposals for health insurance, which come in all shapes and sizes would either enhance the current employment-based health insurance system or put it at risk.

One possibility is to replace the current tax exclusion with a tax credit for all persons with health insurance. Several members of Congress have been discussing replacing the employer deduction for health insurance with an individual tax credit. If the tax credit were refundable, all persons with the same health insurance coverage who claim the credit would get the same tax credit. Another possibility is to leave the tax exclusion unchanged for individuals who get insurance through employment and add a refundable tax credit solely for individuals who do not qualify for employment-based health insurance. For example, recent proposals by some members of Congress would create refundable tax credits that would only be available to individuals who are not eligible for an employment-based health plan. Specifically, one such proposal would provide an $800 credit per individual and a $400 credit per child, up to an annual maximum of $2,400 per family, for those without access to an employment-based plan. Another would provide a partially refundable tax credit worth up to 30 percent of the cost of a health plan for low-income individuals. These proposals are intended to leave the employment-based health insurance system intact, as they are targeted to individuals who are less likely to be covered by an employment-based health plan or ineligible for one.

However, the movement to individual-based tax credits for any source of health insurance coverage may mean the end of the existing employment-based health insurance system. This has potentially enormous public policy implications, since the vast majority of Americans get their health insurance coverage through employers. Such a change may also have political implications, as public opinion currently may not support such a fundamental change in the U.S. health insurance system, as discussed later.

Different proposals for adding a tax credit would likely have different outcomes. For example, some proposals intend to preserve the employment-based health insurance system, while others intend to replace it. Hence, a number of issues need to be considered in any debate over changing the tax treatment of health insurance coverage. Some of these issues are discussed below.

Rep. Thomas and others have argued that health insurance should be completely de-linked from employment and advocate changing the tax code to move away from the employment-based system. In general, this argument holds that the major role played by employers in health insurance fundamentally distorts the economics of the health care market place. Specifically, we should completely replace the current health insurance-related tax code with an individual tax credit. Employers would not be able to deduct the cost of workers' health insurance as a business expense;

[1] It can also be argued that the uninsured would be much higher if workers were not allowed to exclude any portion of health benefits from income, or if employers were not able to deduct health benefit expenses as a business expense.

instead, they would be expected to give workers a cash payment to obtain health insurance on their own. Advocates of this approach envision a private system of universal access to health insurance.

But the assumption that employers would continue to provide the same contribution to their workers' health plan may be questionable. Employers might choose to eliminate their contribution to health benefits and instead pay workers a higher (taxable) wage. Also, limiting the employer deduction would directly affect only those employers that pay federal income tax; it would not, for instance affect state and local governments or nonprofit institutions. However, these organizations would be indirectly affected, as they would be competing for the same pool of workers in the labor market and it is likely that these employers would follow the behavior of employers that are subject to federal income tax.

Proposals for limited tax credits presumably would have less of an effect on the employment-based system than a "pure" individual tax credit. First, under a system where only persons not eligible for employment-based coverage would be able to take the tax credit, some employers might use this as an incentive to terminate health benefits. However, as long as workers continue to demand health benefits and unemployment continues to remain low due to a growing economy, and employers have to compete for scarce labor resources, employers may be reluctant to reduce health benefits. Given the same approach, in an economic recession it would be relatively easy for employers to terminate health benefits, especially if workers could get a tax credit when purchasing health insurance on their own.

A tax credit with aimed at low income individuals would have a much smaller effect on the employment-based system. Under one recently-introduced bill, only single persons earning less than $25,000 and married persons earning less than $40,000 would qualify for the tax credit. Since low-income individuals are least likely to have employment-based health insurance to begin with, the proposal would not be expected to have much impact on employment-based health plans. Under this proposal, persons eligible for the tax credit would be able to claim 30 percent of the cost of health insurance.

Another recently introduced proposal would create a tax credit available to persons with employment-based coverage, but the amount that could be claimed under the tax credit would be much smaller for individuals who are eligible for an employment-based health plan. For example, individuals not eligible for an employment-based health plan could take a tax credit of up to $1,200, while eligible individuals could only take a $400 credit. While the tax credit is targeted toward individuals who are not eligible for an employment-based health plan, employers might still terminate a plan because individuals could then claim the tax credit if they purchased health insurance on their own. In other words, the credit could create an incentive for employers to drop coverage.

Additional Market Reforms—Proposals to change the tax treatment of health insurance in the past were generally combined with insurance market reform. These reforms usually included some type of "community rating," whereby all individuals who wished to enroll in a health plan were charged the same premium regardless of employment, family or health status. In essence, the goal of past proposals was to limit insurers' ability to charge different premiums to groups on the basis of risk, thereby allowing less healthy individuals to buy insurance at the premium that reflects the community's average risk. Some, but not all, current proposals include provisions that would allow smaller entities to band together to purchase health insurance at favorable rates, but in general they allow the market to determine premiums.

Another issue to consider is how employers would distribute funds if they were to eliminate health benefits in favor of higher wages. Health insurance is generally more costly for older individuals than for younger ones, since older people tend to have more health problems. This was reflected in a recent advertisement for a health plan in a local Washington, DC, newspaper, which showed premiums for a 30-year-old ranging from $71 to $86 per month, while premiums for a 60-year-old ranged from $225 to $254 per month. If individuals are charged different premiums because of their age in the nongroup market, employers would face a number of issues in deciding how much money to give workers to buy insurance on their own. For example, would a 25-year-old worker get the same pay raise as a 50-year-old worker, or would the 50-year-old receive a higher pay raise because of the higher expected premium when premiums are not determined by average community risk? With an average premium in the above advertisement being $163, 60-year-old workers would not receive enough money to purchase health insurance on their own if the distribution were based on a community rate. This might result in older workers becoming underinsured and younger workers overinsured.

How employers ultimately distribute the funds would partly depend on how flexible employers could be under any final legislation. For example, employers might be required to "community rate" the distribution, i.e., to divide the distribution equally among all workers. All workers would get the same distribution regardless of age, although single workers might get a lower distribution than married workers if the plan subsidized family coverage.

If all workers received an equal distribution level, it is likely that older workers would not be able to purchase health insurance on their own solely with the funds distributed from their employer. Under the assumption that insurance carriers operating in the individual market are allowed to age-rate the premium, older individuals would likely pay higher premiums than younger ones. In addition, unhealthy individuals could pay more than those in good health. And, if insurers set premiums using experience rating, there might be added pressure on employers to "cash-out" the benefit plan based on an actuarial (age-based) formula instead of a community-rated basis.

A question also arises concerning how the tax credit would be distributed. Current proposals set the credit either on a per-person basis or as a fixed percentage of the premium, and some proposals limit eligibility for the credit to individuals in low-income families. It is also possible to vary the tax credit by health status and/or age. The need to vary the tax credit by age and health status, and the subsequent effects of varying the tax credit, are highly dependent on whether premiums are community-rated or experience-rated.[2] If Congress continues to allow health insurance premiums to be experienced-rated, older and unhealthy individuals will likely pay more for insurance than younger healthy individuals. Under an experience-rated system, policymakers would ultimately have to decide whether to vary the tax credit by age and health status to address the issue of affordability.

THE UNINSURED

One of the concerns over changing the tax treatment of employment-based health insurance is that the change would erode (and potentially destroy) the employment-based system. As mentioned above, a tax credit may induce individuals to purchase health insurance on their own or it may make it harder for vulnerable populations to continue coverage. This has different implications for various segments of the insured and uninsured populations. For example, if only young healthy people choose to opt out of their employment-based plans, premiums would increase for individuals remaining in employer plans, while they would decline for individuals who opt out. This might have the unintended side effect of reducing coverage among individuals who remain in the employment-based system if the cost of employment-based health insurance is less affordable, ultimately increasing the uninsured population.

The current tax treatment of employment-based health insurance has been shown to be regressive. However, removing (or simply changing) the tax subsidy might not increase social welfare, as discussed in Custer (1999). The assertion that the tax treatment of employment-based health insurance distorts the market for health insurance, thereby creating an inefficient allocation of resources, is based on the assumption that the tax preference is the only reason the market for health care services is inefficient. If other factors, such as inefficient and over regulated individual markets, prevent the health care system from performing optimally, the "theory of second best" suggests that changing the tax preference might not increase social welfare. Custer (1999) found that removing the tax preference for employment-based health insurance would have a larger effect on individuals in families with at least one family member in fair or poor health than on families in which all members are in good health or better. Specifically, he found that if the tax preference for employment-based health insurance were eliminated, employment-based coverage would decline 17 percent for individuals in healthy families and 34 percent for individuals in unhealthy families.[3] Similarly, Monheit, Nichols, and Selden (1995/96) found that the employment-based system and its tax treatment act to transfer income from individuals in good health to those in poor health. Essentially, the tax treatment of employment-based health insurance acts to promote participation in

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[2] The value of the tax credit is also affected by geographic region, as health care costs and health insurance premiums vary by geographic region. Policymakers will also need to determine whether the value of the tax credit should be higher in high-cost regions, though they could simply set it at a fixed percent of the health insurance premium.

[3] Custer (1999) found that the percentage of individuals in healthy families with employment-based health insurance would decline from 70 percent to 58 percent. The percentage of individuals in unhealthy families with employment-based coverage would fall from 47 percent to 31 percent.

health plans among low-risk individuals, which ultimately assists the pooling of risk.

Changing the tax treatment of employment-based health benefits might affect the overall level of the uninsured. Custer (1999), for example, found that removing the tax subsidy would reduce the number of individuals covered by an employment-based health plan by more than 20 million. While he finds that 3.5 million individuals would purchase coverage in the individual market, many others would not, resulting in a substantial net increase in the uninsured. Even if the tax treatment were changed so that anyone purchasing health insurance qualified for a tax credit, affordability would continue to be an issue for low-income workers.

Even repackaging the tax credit might affect the level of the uninsured. Thorpe (1999) found that introducing a tax credit would reduce the level of the uninsured, but the reduction would depend in large part on the level of the tax credit. Specifically, he found that a tax credit of $400 would result in 18 percent of single uninsured workers with incomes at 150 percent of poverty to participate in a health plan. At a tax credit of $800, their participation would rise to 22 percent. As mentioned above, some proposals set the tax credit at $500 for a single person. In order to achieve a take-up rate of 75 percent, Thorpe (1999) determined that the tax credit would need to be set at $2,800 for a single low-income uninsured worker.

While some members of the uninsured population would gain coverage under a tax credit system, others in the employment-based system might drop coverage, leading to a net change in the level of the uninsured that could be positive or negative. Attempting to model this net increase, Cox and Topoleski (1999) found that the uninsured would increase between 0.2 million and 24 million people, depending on the generosity of the tax credit and the parameters used to determine eligibility for the tax credit.

CONCLUSION

There are trade-offs involved in providing individual tax credits to those who might have access to health insurance through the workplace. In some cases, employers could be given the incentive to drop coverage, in the knowledge that their employees could purchase it for themselves. In other scenarios, enough individuals would leave the employment-based system to destabilize it, resulting in even more distorted insurance markets and causing the number of uninsured to rise.

If the goal is increased coverage, the structure of the health insurance marketplace cannot be ignored. As many policymakers have recognized, changes in the tax code designed to facilitate the purchase of individual health insurance will almost certainly have to go hand in hand with insurance market reforms. Here, there are profound questions regarding the proper Federal role in the process. In essence, none of the changes discussed above can or should take place in a "vacuum."

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Chairman THOMAS. Yes, I would very much like it if you would respond in writing to that question because we are going to be facing those questions very soon. The gentleman from Pennsylvania wishes to inquire?

Mr. ENGLISH. Yes. Thank you, Mr. Chairman. Mr. Sheils, in your testimony I think you have said some provocative things, but I par-

ticularly wanted to explore and amplify on the question that Congress is going to have to grapple in any health care reform legislation.

It is specifically, in your view, how close and how direct is the relationship between the increases in the cost of health insurance and the increases in the uninsured rate? How close is that relationship? How predictable is an increase in the uninsured rate, following an increase in costs? And I am curious, given that CBO has informed Congress that perhaps a 1-percent increase in insurance rates might yield a 200,000 increase in the number of uninsured nationwide, does that figure seem realistic to you? Does it seem low? Does it seem high? And how does that conform with your research?

Mr. SHEILS. Well, thank you for asking that question. We did do a study where we tried to examine the determinants of insurance coverage; why are people losing coverage? We looked at demographics. We looked at the shift to the services sector. We have looked at the shift from full-time to part-time employment. Looked at the availability of Medicaid. And we tried to build a comprehensive model that measures all of this in there while, in addition, adding in price, the price that workers are paying for insurance.

The analysis showed that about 75 percent of the loss in coverage that we had experienced since 1989 was attributable to the increasing price of insurance. Our estimate—this was an independent estimate. It had nothing to do with CBO's work and I don't think theirs had anything to do with ours—our estimate indicates that a 1-percent increase in the premiums paid for health insurance has been associated with an increase in the uninsured of about 300,000 persons. Now I believe CBO's number is 200,000. I know there was another time they did an estimate where a 1-percent increase was going to result in something like a 400,000-person loss of coverage.

That is not an enormous number. It is three Sugar Bowls full of people, but it is not an enormous number, as some people had postulated. But it is a very—I think it is a very solid relationship at this point. It is very simple. You raise the price of anything, fewer people are going buy it. Fewer people can afford it.

Mr. ENGLISH. Well, I think——

Chairman THOMAS. Will the gentleman yield briefly on that?

Mr. ENGLISH. Absolutely.

Chairman THOMAS. Now were you able, then, to extrapolate beyond that? Is that an arithmetic increase? That is, if it is a 2-percent increase, you would lose between 400,000; 600,000; or 800,000? It tends to just move up arithmetically?

Mr. SHEILS. Roughly, yes.

Chairman THOMAS. Roughly. OK. Thank you. I thank the gentleman.

Mr. ENGLISH. Well, that is extremely useful research as we go forward. I am curious, in your testimony, you focused on the number of workers, the percentage of the uninsured who were in fact workers who declined employer coverage. Now we know that some people who are young consider themselves immortal so they don't need that sort of stuff. But I am curious if you can give us any greater detail with regard to the motivation of the workers who de-

clined employer coverage? Can you give us any insight into why that statistic is so large?

Mr. SHEILS. Research actually was done on this where we looked at the cost of insurance to those workers and it indicated that price was a major factor, the price of the family coverage. But you can get insurance for these people, say $50,000, you can get insurance with a catastrophic cap for many of these people—and they tend to be younger. I know of one woman with a child who is getting it for $100 a month. That is what it is costing her. Now it is catastrophic insurance. She has to spend several thousand dollars out-of-pocket before it kicks in, but the person was able to get insurance.

I can't tell you what the psychology is. I remember I had a painter come in and do my house. He had a great truck. I think he was making around $50,000, but he just did not believe in health insurance. We didn't see eye-to-eye on that and we didn't see eye-to-eye on the paint job, either.

Mr. ENGLISH. One last question. How much of this could be driven by part-time workers who are actually eligible for a medical card and who, unbeknownst to anyone, actually are eligible for benefits and utilizing public benefits, but who might not show up in the survey?

Mr. SHEILS. Well, there are people who are using—I am not sure I understand the question. I know there are lots of uninsured people who are using publicly funded clinics and that kind of thing.

Mr. ENGLISH. Surely. I guess, did your survey factor out people who were actually on public programs, in terms of workers who declined employer coverage?

Mr. SHEILS. That is right. We sorted out those people who—oh, I see. How many of those 10 million who also have access to public coverage?

Mr. ENGLISH. Right. Exactly.

Mr. SHEILS. Some of them, presumably, could have qualified for public coverage. But the point is they are uninsured. They haven't enrolled in that either.

Mr. ENGLISH. OK. Thank you very much. This has been most informative.

Mr. SHEILS. Thank you.

Chairman THOMAS. I thank the gentleman. Does the gentlewoman from Florida wish to inquire?

Mrs. THURMAN. Yes, I would. Thank you, Mr. Chairman.

Overwhelmingly, the one thing I hear from everybody on this panel is that it is the cost of insurance which is causing the problem. With that is associated what has happened with the cost of health care increases. Ms. Arnett, you mentioned in your testimony that you had looked at 16 States on the mandates issue. When you compared the increases in mandates suggesting that those mandates were also the cause of the increase of the health care insurance costs, did you look at the States where those mandates had not and what the difference was between those percentages of increases?

Ms. ARNETT. Yes, Mrs. Thurman. In the 16 States sample, there were some States that were very—that already had very high rates of uninsured and some States that had very low rates of uninsured.

The study didn't include only States with high uninsured rates. And we did look at the impact of regulation across the board, things such as guaranteed issue, guaranteed renewal, portability, a range of issues that had been identified by the GAO. And the 16——

Mrs. THURMAN. And those were things that increased the costs?

Ms. ARNETT. Well, we did not do a cost analysis. We tried to, but it was very difficult to do that as a think tank. Insurance companies just don't give out complex and proprietary pricing information to outside organizations. It is very difficult to equate it with costs. That is why we looked at uninsured rates, which is something collected by the Census Bureau where we could get an objective analysis based upon the same data set across all States.

Mrs. THURMAN. I think the thing that concerns me, particularly when it comes to things like portability or existing diseases, which, you know, that we have tried to cover——

Ms. ARNETT. Preexisting conditions, right.

Mrs. THURMAN. The other issue is, though, I think we have all been told over the years that more people that are uninsured and don't have health care is also creating the cost of insurance or health care to this country. I feel like I am just going around in this vicious circle. And I am not sure what the answers are, Mr. Chairman, other than the fact, I have to say, that I think the idea is that the more people we get insured—and this is a question—does that help us bring down health care costs?

Ms. ARNETT. I think, overall, that is exactly right. The data certainly show that. But the question is why people are losing private health insurance coverage. In the States that are regulating the small group and individual markets, where the impact of these regulations hits hardest, that is where you see the coverage fall off. That is one important reason why the percentage of those with private coverage has fallen from 79.5 percent in 1980 to 70.5 percent now.

Mrs. THURMAN. But then I would go back and suggest sometimes government is not all bad in this case, then. The issue here is—and maybe any one of you can respond to this—would be what Mr. Stark has suggested and we are looking at. It may only be 400,000 people that you look at from age 55 to 64. It may be only 10 million children that you are looking at below. But you are still providing coverage and, as you provide that coverage, it should, by testimony and everything else we have heard, should drive down some of the cost associated both with insurance and health care coverage. Would you all agree with that?

Mr. FRONSTIN. I think it was more likely to be true in the past when it was much easier for providers to cost-shift onto people that had insurance, but with managed care squeezing out a lot of that ability, I don't see that relationship being as strong as it used to be.

Mrs. THURMAN. Now we are just cost-shifting it to a whole lot of other folks that don't have insurance or who might have but are still paying for certain pharmaceutical assistance, whatever. Go ahead, Mr. Sheils, I am sorry.

Mr. SHEILS. I am not sure. It has long been held that getting everyone insured would somehow reduce the cost. We always shown an increase in cost.

Mrs. THURMAN. If everybody is insured?

Mr. SHEILS. Yes. And it depends on how you do it. If you do it with a system of proper incentives, you can save some money. But we are getting to the point where we are talking about many tens of millions of people here. It is hard to imagine that giving them coverage would result in a net reduction of costs.

Mrs. THURMAN. When you say incentives, I just was looking at a CRS report here that talks about all the tax incentives that might be available to folks. And one that I looked at was the self-employed deduction. We have the individual private market policies. We have the cafeteria plans. We have the MSAs. Over and over and over, we have lots of insurance incentives for people to buy.

Here is a question. Under the self-employed deduction part, of that group, how many are insured that already have an incentive built into the law? Do we know?

Mr. SHEILS. It is not on us. Well, in our filing cabinets, I am sure. I just don't have the numbers with me.

Mrs. THURMAN. I think we should look at the programs that we already have available as to who has signed up for those and find out where the best incentive has been instead of just saying, arbitrarily, oh, just do a tax credit. That will take care of the problem.

Mr. FRONSTIN. It is not that simple just to look at the self-employed to see whether or not they are covered.

Mrs. THURMAN. Farmers——

Mr. FRONSTIN. Because a lot of them are covered—it is about a 50–50 split between coverage in your own name through your own business and coverage from a spouse. And that just makes it very difficult to do any kind of analysis. You know, when you introduce family incentives and those loosening the constraint of where you can get coverage from.

Chairman THOMAS. I thank the gentlewoman.

Mr. HOLAHAN. I was——

Mrs. THURMAN. Can Mr. Holahan?

Chairman THOMAS. Go ahead.

Mrs. THURMAN. Thank you.

Chairman THOMAS. It is just that we have got a vote on.

Mrs. THURMAN. I know.

Chairman THOMAS. And it is going to be tough. I would exercise the option and recognize the gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman. I begin by saying that there are others of us on this Subcommittee who think we have the answers too. Mr. Stark is not the only one who thinks he has the answers. There are plenty of answers to go around. I think it is useful to examine some of the forces that are driving the uninsured to be uninsured. And so, to that extent, I appreciate the panel's testimony.

And, also, in defense of my good friends, the small business people in America, some of whom joined the NFIB and are polled by the NFIB and that poll was cited by my friend from California, I think it is probably an accurate result, but it is not surprising for

the very reason stated by the panel. Mr. Fronstin, particularly, he said that small employers don't generally have the time to go out and seek health insurance for their employees, negotiate with various providers of insurance. Or at least they don't think they have the time and they don't want to take the time.

It is not the cost, necessarily, that is the problem, not the cost of the insurance. It is the cost to the employer. It is the cost to the small business person who has to take his time, which is a cost, to go out and get that insurance. That is not a surprising statistic. It is perfectly reasonable.

I would like to know from the panel if any of you know what percentage of the insured who receive a subsidy for their insurance—or, I am sorry, who do not receive a subsidy for their health insurance? What, of the total universe of insured people, some get a subsidy through government, direct government insurance, Medicaid, Medicare. Some get a subsidy through the Tax Code, through getting it through their employer. And then there is that group that doesn't get any subsidy at all, mainly in the individual market.

Do you know what percentage of the total universe of insured is represented by those who get no subsidy?

Mr. HOLAHAN. About 5 percent.

Mr. MCCRERY. About 5 percent?

Mr. HOLAHAN. Of the nonelderly population, about 5 percent have nongroup coverage. I think that is your question.

Mr. MCCRERY. Is that generally what you have found, the other panelists?

Mr. SHEILS. Well, there is a group out there that doesn't have an association with an employer that has employer coverage. And I think we are looking at something—I will check this out, but I think it was in the neighborhood of 40 percent of those people were taking that coverage. But those people are also much lower income. That is a large part of why they did not get the coverage. For those who weren't associated with employment, there was a slightly higher percentage of persons who had coverage. But these, again, are people who had no subsidies whatsoever from the government. They were simply—no association with employment.

Mr. MCCRERY. Right. But can you give me how—what slice of the uninsured pie is represented by those people who get no subsidy? Mr. Holahan says 5 percent.

Mr. HOLAHAN. It is 5 percent of all the nonelderly. It is hard to understand——

Mr. MCCRERY. Is it a small percentage?

Mr. SHEILS. I think I know what you are looking for. I can try and find the number and then get back to you.

Ms. ARNETT. The percentage of the insured or the uninsured?

Mr. MCCRERY. No, the insured. Now you have got a pie here that is made up of all of the insured people in the country. What slice of that pie is made up of people who get no subsidy? It is a fairly simple question. If you don't know the answer, that is fine. Just tell me.

Mr. HOLAHAN. It is 5 percent.

Ms. ARNETT. Right. I would think 5 percent, too.

Mr. HOLAHAN. It is about 5 percent who have private, nongroup coverage, who are not getting a subsidy. I think that is your question.

Ms. ARNETT. Right.

Mr. FRONSTIN. But you are including in that, in your question, you are defining subsidy as including the tax exclusion?

Mr. MCCRERY. Surely. That is a subsidy.

Mr. FRONSTIN. OK.

Mr. MCCRERY. Right? That chart over there shows the distribution of that subsidy. And it is a very graphic—it is a very good chart. It shows that people in this country who make a lot of money, defined by the Democrats as about $40,000 a year, Republicans a little higher, get a pretty big subsidy from the government. They are subsidized. People who make $25,000; $30,000; $35,000 don't get much. In fact, a lot of them don't get any subsidy. Most of them don't get any subsidy.

I think that chart is worth taking a look at for Members of this Subcommittee. Do we want, if we have dollars to spend to subsidize health insurance in this country—which I question outright—but if we are going to do it, if we are going to subsidize health insurance, why are we subsidizing people who have the wherewithal to buy it for themselves to begin with? Why aren't we subsidizing the people who need the help? Now we do at the very low end, with Medicaid, but then we get into private health care, we are subsidizing the top earners in the country. It doesn't make much sense to me.

If you subsidize something, you get more of it. Any of you economists? That is generally true, isn't it? If you subsidize something, you get more of it. OK. We have subsidized health insurance. We got a lot of health insurance. Also if you subsidize something, if the cost goes down——

Chairman THOMAS. If the gentleman would suspend. If the gentleman would suspend.

Mr. MCCRERY. I am on a roll, Mr. Chairman.

Chairman THOMAS. I understand that, but we have got a vote on and it sounds like we want to come back. And I am going to ask the panel——

Mr. MCCRERY. I would love to.

Chairman THOMAS. Do you want to come back? Then let us recess and come back, because I know two Members want to inquire and there may be some followups. I apologize to the panel. We will be back after two votes. The Subcommittee stands in recess.

[Recess.]

Chairman THOMAS. If the panelists will return to their designated seating area.

And the Chair apologizes to the gentleman from Louisiana—if he can rewind his roll.

Mr. MCCRERY. Mr. Chairman, I appreciate that although I have to say, in fairness, the red light had come on. My time had expired. If you would give me another round, I would be glad to defer to my—is that OK? OK.

Chairman THOMAS. Well, the Chair believes that he will allow you to go ahead.

Mr. MCCRERY. Well, I appreciate that very much on the part of the Chairman and the gentleman from Washington. We were talk-

ing about subsidizing health care. And over the time we were voting, from two different sources, we discovered that the percentage of the pie that is accounted for by people who receive no subsidy is about 5 percent. It is a very small percentage of the insured pie that is bought by people who get no subsidy. And that is no wonder, is it? If your car were subsidized, you would probably buy a car a lot sooner than you would if it were not subsidized.

And then I was going to make the point that if you subsidize something, you get more of it. Just, in the marketplace, if you subsidize some product, you are going to get more people buying that product. Just stands to reason. And that gets me to the point of why costs have risen in the health care marketplace. You have all pointed out that costs are a problem and increasing costs account, at least in part, for the growth in the number of uninsured in this country, but why are costs increasing?

I think one reason costs have increased is because we subsidize the costs. If you don't have to pay the full price of it in the marketplace, you are going to get a lot more of it. And I think that is true for health care just as it is for food or shelter or anything else.

And so, you know, I think we have got to get at the causes of this and if you hide the true cost of something, you are going to get more of that product. And I think that is what we have been doing in health care for far too long, we have been hiding the true costs of health care through subsidizing through Medicare, Medicaid, the employer, the work place. And so what can we do about that? Well, there are a lot of things and I have got all the answers but I will save those until I have a discussion with my friend from California.

But one question I would like to ask the panel is can we have an efficient health care system without universal coverage? Isn't our health care system right now terribly inefficient? It is convoluted. We have got government-paid health care up here for the elderly. We have got government-paid health care down here for the poor. And then we have got this private health care marketplace that looks like a Byzantine mess. Group markets and individual markets and big groups and small groups and moderate groups and it is not very efficient, is it?

Mr. SHEILS. The efficiency of the system is that there are things we like about our system because of the different types of insurance you can pick and choose. That is choice. Americans value that. But it contributes to inefficiency and makes things very, very cumbersome to operate. We stay away——

Mr. MCCRERY. Well, you say that we have choice, but if I am working for a small business and my employer doesn't provide insurance for me, what choice do I have? If I am living in Alexandria, Louisiana.

Mr. SHEILS. If you have the money to buy the insurance, you can go out and buy it. If not——

Mr. MCCRERY. I can buy what insurance?

Mr. SHEILS. You can usually buy—you can buy catastrophic insurance very often from individual——

Mr. MCCRERY. In what market do I have to purchase that insurance?

Mr. SHEILS. Well, I just earlier cited an example of at least one case where that happened. I am not trying to say that——

Mr. MCCRERY. Yes, I have got to the individual market. I can't get the same advantage that my neighbor has working for GM. I don't have much choice at all in the marketplace.

I hear what you are saying and we love choice, but I am just wondering if—a lot of people in our society don't have much choice when it comes to health care and that is part of the problem. That is why they are uninsured because, number one, they have got to go to the individual market, which is higher cost than the group market. Number two, they get no subsidy from the government for purchasing, so they are at a distinct disadvantage to their neighbor, who does get a subsidy. It is no wonder that they don't buy it. It is not a good deal. It is a bad deal.

Mr. SHEILS. Well, I think there is a simple truth about the uninsured population that perhaps wasn't explored very much in recent years. But the uninsured are composed of two groups of people: People who want insurance but can't get it and people that can get it who don't want to buy it. There was an interview in 1994 in Money Magazine. They were interviewing all the various stakeholders in health insurance and asking what they were afraid of. Go to employers: Well, what are you afraid of? The government: What are you afraid of? And then they went to uninsured people. And the most often cited thing that they were afraid of is that they would have to start paying a premium.

Mr. MCCRERY. Surely.

Mr. SHEILS. Some people just don't feel it is worth buying in.

Mr. MCCRERY. That is right. And, in fact, a lot of those people who don't feel like it is worth buying in are young and healthy and they have got other priorities. And that is swell, except if you think of health care as something that people require and that everybody ought to contribute to in our society. They ain't contributing anything, are they? And so they do contribute to the inefficiency in the system. Go ahead, Ms. Arnett.

Ms. ARNETT. That is exactly right. Because it is inefficient to have so many healthy young people not participating in the insurance pools. By not participating, they wind up causing everybody else who is in the pool to pay higher prices. And when the costs are so invisible, as you so well point out they are, then everybody thinks everybody else is paying for the cost of their health insurance, and it drives up the cost further for everyone. And we wind up in this spiral that we are in right now.

One of my colleagues on the consensus group said, concerning this trough, when you are in a hole, you want to stop digging. And one of the things that I think that is really important is to look at what has been causing the problem and see if we can stop digging and start filling up the trough.

Mr. MCCRERY. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. The gentleman from Washington I know wants to inquire.

Mr. MCDERMOTT. I want to congratulate the Chairman for having our annual socialism versus capitalism discussion on health care. But rather than get into that fight, I liked the line of questioning Mr. McCrery was going down.

In fact, he stole my first question, which was: Is there an acceptable level of uninsured in a society? We have an acceptable level of unemployment, 4 percent or something. You know, I don't know. Everybody says we are going to have full employment. What they really mean is there will only be 4 percent that we are counting that are not employed. How about insurance? You are all policy wonks so you don't have to think about the things we do. Is there an acceptable level of uninsured in a society, say 10 percent? Or 5 percent? Or do you think that it ought to be at zero?

Mr. FRONSTIN. I am afraid that we haven't even reached that, the acceptable level. If you think about it, if unemployment doubled, if it was at 10 percent or 8 percent as opposed to 4 percent, it would be on the front page of every newspaper. The uninsured being at 17 or 18 percent is barely making page 25 in most newspapers. We may not have even reached that level to trigger, you know, national interest in this issue.

Mr. SHEILS. I have been waiting to get that question asked to me for about 12 years now. I think it is quite possible that there is an acceptable level of uninsured persons. I think there are a lot of complaints about our current health care system and many ways in which we want to improve it, but, arguably we are getting along. We are getting along. Most people have insurance. Most of those people who are uninsured, who get care when they sick, signed up for Medicaid when they go to the hospital.

Unfortunately, what the big problem here is that people aren't getting their primary and preventive care, which is very important to preventing illnesses. But I was just going over an example during the break. Back in 1993, I was asked to look at the number of health reform proposals and figure out what it would cost to provide the premium subsidies and so on. The cheapest plan anyone ever gave me to cost out was in the neighborhood of about $60 billion. Uncompensated care——

Mr. MCDERMOTT. Sixty billion dollars?

Mr. SHEILS. Sixty billion dollars. The Federal Government would have to come up with $60 billion to provide subsidies—I am sorry?

Chairman THOMAS. Over 5 years or 10 years?

Mr. SHEILS. One. One year. Now my point is that we were spending $60 billion in Federal money to wipe out a $22 billion problem. You could look at it that way. It is more complicated than that. I don't want to get into trouble for this, but if you take the position that people who are not insured are freeloaders and you are sick and tired of paying for them through cost-shifts and whatever might be happening, the odd thing is that if you go to universal coverage, you are talking about a program that is actually going to cost the government more and, since there is only one place to get that $60 billion and that is from people who have money. They are going to have to pay in money so that we can help other people have insurance. There is no other way to do it. And you might find that the individuals who are most concerned about the freeloading in the end would find that they are paying much more to finance this program to make sure that everybody has coverage.

It is very remarkable to me that during the health reform debate we did not see more support coming from the uninsured. We did not see great marches on Washington demanding health coverage.

We have had those, the poor person's march in 1965 I think it was. But we didn't see it.

Mr. MCDERMOTT. You are really agreeing with Dr. Fronstin that we have not reached a level where it is a real problem. We are having this discussion and we have these hearings periodically and go around and around. People put in bills. But from an economic standpoint, it really doesn't make any sense to even worry about those 16 percent who are uninsured. On an individual basis, yes, maybe, but not as a policy for the society. Is that what I am hearing you are saying? $60 billion versus $22 billion and so why worry about it?

Mr. SHEILS. I think the level of uninsured is too high. I think that we may have——

Mr. MCDERMOTT. On an economic basis, do you think that?

Mr. SHEILS. Yes.

Mr. MCDERMOTT. Or are you just talking socially, as a good public policy?

Mr. SHEILS. A bit of both.

Mr. MCDERMOTT. A bit of both. The reason I raise this question is because I listened to Mrs. Johnson and she was talking about a subsidy and I am probably the only guy up here who has actually had an experience with doing that in the State of Washington. We created the Washington basic health plan and had a sliding fee scale for people up to 200 percent of poverty. And the problem we ran into was the legislature's unwillingness to provide enough money to cover everybody who came forward saying they wanted into the Washington basic health plan. And we had 70,000; 80,000 people on a waiting list at one point.

And I am not sure what level of subsidy—I haven't looked at her particular legislation—but what kind of—and I also hear the insurance companies now talking about the fact that we ought to have some kind of subsidy for the people at $20,000 up to $50,000, somewhere in there. If we would subsidize they would buy. Have you looked—has anybody looked at the figures as to what we are talking about and what that would mean, in a realistic world?

And ours was voluntary. That is the other thing. And at some point we have to come to grips with the question Mr. McCrery asked about mandatory versus voluntary. And I don't know.

But tell me about the subsidy question.

Mr. HOLAHAN. Could I just respond to that? Yes, I think for this to work, in terms of expanding coverage significantly, the subsidies have to be pretty generous. People do not respond to subsidies unless they are. And we are seeing that in a lot of places, including the State of Washington. Even though costs went above what the State was willing to pay, participation rates went down as people were required to pay more, went down.

The other point is the whole issue of selection or adverse selection. It is very likely that the people you are going to get covered are going to be sicker than average. They will be the ones that will take advantage of the credit, and that is good, because it means you are kind of targeting on the people who probably need it the most, but the cost per covered person is going to be high. To go further and make the subsidies more generous, you will be bringing in healthier people, and the cost per new person would be lower.

But I think the whole issue of selection is something that you will have to really grapple with.

Mr. SHEILS. We did a simulation of this on the tax credits. We looked at the $2,400 tax credit for all families, less for single individuals, everybody, and it brought it maybe 6.6 million people; 6.6 million out of 40 million uninsured, however you are measuring it. We did it again where we cranked it up to something like 80 percent of the premium.

Mr. MCDERMOTT. Eighty percent?

Mr. SHEILS. Yes, just for fun, and we got something like 10 or 11 million. And we are basing it, basically, on the study I mentioned earlier where we look at the extent to which a change in the price of insurance changes the likelihood that somebody would buy coverage. Basically, a 1-percent increase in the cost of insurance—in this case, via the tax credit—should result in something in the neighborhood of a 300,000-person increase in the number of people with insurance.

Mr. MCDERMOTT. Could I just stop you on that. On the basis of that figure, you are anticipating, next year, 3 million more people, since most people are talking about a 10-percent increase in price. You expect another 3 percent will be uninsured at the end of the next fiscal year?

Mr. SHEILS. Yes. You would see quite a few more people uninsured if the cost went up that much. I don't think they are going to go up 10 percent, but I think a lot of people——

Mr. MCDERMOTT. At the FEHBP, they are already talking 10 percent, and Calpers is talking——

Mr. SHEILS. I know, but I also know that brokers are going to their clients now with those figures, and they also always have in their briefcase some other policies to sell them that are more restrictive, more managed care, something like that. So, what happens is employers see the picture, and they say, "Whoa, no way," and a lot of them will respond by asking for less costly health plans, and I know the brokers are going out prepared for that.

Mr. MCDERMOTT. Let me, then, come back to this question of mandatory versus voluntary. Can we ever deal with this problem if we don't make it mandatory?

Mr. HOLAHAN. I think you could partially deal with it. I think depending on——

Mr. MCDERMOTT. Well, we are partially dealing with it now.

Mr. HOLAHAN. No, but you can even more so. The more you subsidize, the more people you will bring in, and they will tend to be, on balance, healthier people. But to get the universal coverage, in my view, you are going to need to have a mandate, and, in my opinion, it would be on individuals. That is the only way that you can get there. You will do a lot of good with the tax credit approach.

Mr. MCDERMOTT. So, the subsidy program would basically be, in your mind, then, a kind of a high-risk pool, a national high-risk pool?

Mr. HOLAHAN. Well, it will have somewhat the same effect. The high-risk pools really get extremely get high risks.

Mr. MCDERMOTT. Yes, but——

Mr. HOLAHAN. But, you would have a broader mix of risk than they tend to, but it would—I think that is what would happen.

Mr. MCDERMOTT. One of the problems we found in our subsidy program was that you had to be sure you, we believe, don't lock people in; it is month by month. So, if a woman gets pregnant; she joins the program; goes for 9 months, has the baby and then drops out. So, we had lots of those kinds of problems too, because we did not have a mandatory 1-year or some kind of lock-in where we actually had some stability in the program. We found lots of problems with the subsidy program through our experience with that over this, and I am not sure—I come to mandatory coverage not because I have some kind of preconceived ideology but because of experience with trying to coax people in. It hasn't worked. We are now trying to coax people in with a tax incentive, and I would like to hear what you think about the 30-percent level. Some people have put it at 50 percent; some have put it at 100 percent. What is going to be the difference in effect between the 30-percent tax credit and the 100-percent tax credit?

Mr. SHEILS. It is fascinating. It is really fascinating, because even Medicaid is a program which is free. You have to fill out forms, and it is time consuming, but it is free, and, people who—we get something like 60 to 65 percent participation rates in that program in cases where you are not also providing cash assistance. Just for health insurance, maybe closer to 60 percent of the people are actually signing up; 40 percent don't sign up.

One of the reasons for that is that I think it is understood that if you get sick and you go into the hospital, you are going to be cared for. That responsibility is there to care for you when you get sick. Interestingly, there is no corresponding responsibility on the rest of society to pay for that or for that individual to contribute, but it seems to me that if you go to a 100-percent tax credit—I am mixing points here; I apologize—but if you go to a 100-percent tax credit, you might get 60 percent of the uninsured to sign up at the very most, and if you do a 30-percent credit—I have done some of these numbers—you will only get 3 or 4 million uninsured, as I recall. I don't have those numbers in front of me, but you really don't have that much impact on the number of uninsured, and for low-income people, a 30-percent credit, you might as well be asking them to pay the whole premium. If you are very low income, 30 percent of a $4,500 premium is just too much, and that is the main problem.

Mr. MCDERMOTT. I thank the Chairman for his generosity——

Chairman THOMAS. Oh, no, we are going to get back to you. I think the gentleman from Louisiana wants another round, and I want to just take some of your points and bring them back to a draft and ask the questions in a slightly different way.

There are some self-correcting factors, as Mr. Stark indicated, that on the Medicaid, if you eventually need some medical attention, you will tend to be picked up in the system, and I don't know how long it has been if that has been done that you wind up counted as not being in the system again if you don't go back through it, because I have a hard time dealing with that 13.4 percent never bumping into the health care system at some point and getting picked up or if they in fact are all virginal folk who have never

been to a hospital or an emergency room and they are just out there. So, when you look at some of these numbers, it is kind of difficult to have as complete a comfort level as you would like.

Just briefly, in terms of Mr. Holahan's chart, I want to ask it this way: the question—this is figure number four, to help insurance coverage of adults 18 to 64 years of age by State, and it pulls together a number of factors implicitly in the way the chart is set up. Part of the debate that we go through is from a tax committee point of view, we are talking about subsidizing the current insurance product in the market versus maybe changing the insurance product in the market and then subsidizing, and the frustration is that if you try to subsidize current insurance products in market, you are going to get the kind of numbers that you indicated where you spend an awful lot of money and get a 6-percent increase in those people who probably would have the highest propensity to be captured if you changed the insurance product and market in the first place of their own dollars, if you could create an attractive product, which is the most frustrating part. So, we are spending money, in my opinion, not very wisely.

But the thing that I wanted to ask you about, chart 4, in looking at, Mr. Holahan, some of Mr. Sheils' and Mr. Fronstin's statistics, they obviously, in my opinion, show up on here, and—tell me if I am not correct—and is this the kind of a guide, maybe, that if we wanted to have maximum impact on the uninsured that we could begin to follow? When you look at the lower States—Florida, California, Mississippi, Texas—you obviously have the ethnic and racial minority inclusion. You also happen to have States that have a very high agricultural component and, except for Mississippi, a high population that would deal in a low-income employment on services, and all of those, then, would impact as compared to, notwithstanding the fact that Wisconsin and Minnesota are agricultural States, the kind of agriculture would be more yeoman farmer, family support structure, and high-dollar value as opposed to some of the row-crop activity and fewer ethnic and racial minorities.

So, what about beginning to—if you are going to subsidize the current insurance market and product instead of changing that market, wouldn't you want to try to target some of those subsidies to those profiles of folks, and would you get, for example, a better percentage of the dollars invested in helping if you in fact try to figure out how to deal with specific groups, whether they be ethnic, low income, agriculturally related?

One of the things we have tried to do is where employers of—an employee may have multiple employers in the agricultural work, try to create an ability to pull together all those employers in multiple employee arrangements that could exercise some of the ERISA benefits. That would be one way of getting at that kind of a group. Would that produce better percentages of the dollars spent or should we really just spend time on insurance, the market, the product, and make fundamental changes in that, because I think, in part, that is what the gentleman from Washington is talking about as well? The Tax Code does not afford as many remedies, ultimately, as other areas of law change. Is that a fair statement, and where do we get the best bang for our buck in terms of investing?

Mr. HOLAHAN. Well, you have covered a lot of ground. I think that it would be hard to figure out how to design subsidies that would get at racial and ethnic groups without others.

Chairman THOMAS. You could get at that short handed by employment, couldn't you, to a very great extent?

Mr. HOLAHAN. But I thought that you were suggesting we already do that very well which may explain some of the geographic differences.

Chairman THOMAS. No, I think that is why we don't get at it very well; that, in fact, you have the high unemployment in those States that tend to have heavy agriculture, low income——

Mr. HOLAHAN. More services.

Chairman THOMAS [continuing]. And services which produce that 27 percent of unemployed, and that if we target it, agricultural work, in a way to organize the opportunities to present insurance differently.

Mr. HOLAHAN. I see what you are saying. And that seems to be that it would clearly improve upon the situation that is there now, to a degree.

Chairman THOMAS. Yes, but in marginal increments. You are just subsidizing at 80 to 100 percent on the credit, which eats up enormous amounts of money, and we get a bump of 10 to 12 percent from a particular group.

Mr. HOLAHAN. But by organizing those pools, when you are going from, lets us say, the administrative cost load of say 30 to 40 percent down to 10 to 15 percent, it is still a—let us say, it is a 20-percent reduction in price. You are still not going to pick up a lot from that.

Chairman THOMAS. Yes.

Ms. ARNETT. Mr. Chairman, Americans expect that health insurance to be associated with the workplace. Many of the 43 million are uninsured because they are between jobs and are temporarily without health insurance. Many are really just kind of in a waiting pattern. More and more people find themselves moving from job to job, are much more mobile, and also starting their own companies. Many work for small businesses that are not yet able to afford to provide health insurance but eventually will. But it also is partly the mindset of the American people that they are just waiting until they get job-based coverage because that is where they expect to get health insurance. In a culture in which people think of health insurance as something they own, control, and keep some continuity, then I think individually based tax subsidies could change the equation.

Chairman THOMAS. OK. The gentleman from Mississippi—from Louisiana. I don't know why I am trying to put you in Mississippi.

Mr. MCCRERY. That is all right, Mr. Chairman. We love our neighbors in Mississippi.

Ms. Arnett, you talked about the effect of regulation on cost, and you also noted a study that you did comparing growth rates on the uninsured in some 16 States that you defined to be highly prescriptive in terms of insurance regulation. Can you expound upon that?

Ms. ARNETT. Actually, we looked at two studies that the GAO had done and identified 16 States that had passed a majority of insurance regulations in the GAO studies. States passed these regu-

lations to try to increase access to health insurance for those citizens through guaranteed renewal, guaranteed issue, community rating, portability, and other fair standard kinds of insurance regulations. The thing that surprised us is the unintended consequences that, in their genuine effort to try to use the tools that they had in passing laws and regulations, that their efforts appear to have backfired. The first year after all of those regulations were in effect, those 16 States wound up with uninsured rates rising 8 times faster than the other States that had not passed this package of insurance regulations. But it is very difficult now to do a differential study, because some of these provisions have been passed federally. The majority of those States still continue to have rising rates of uninsured. Despite genuine efforts to try to solve the problem by dictating to the market, that is not working, and this suggests to us that other solutions might be very well worth considering.

Mr. MCCRERY. When you say that the number of uninsured or percentage of uninsured went up in these States, can you give us reasons why? You seem to be trying to make the connection between State regulation and the level of uninsured, but did the State regulation drive out insurers from the marketplace, whereby——

Ms. ARNETT. In many States—that is true, yes. In Kentucky, for example, I think they wound up with just a handful of insurers left, because they couldn't afford to provide health insurance. Some companies that want to provide health insurance in every market have found that those 16 States are the ones in which it is most difficult to provide affordable health insurance. They wind up staying in and only people who know they are going to use expensive health insurance wind up being in the pool, and you wind up with——

Mr. MCCRERY. Why would an insurance company leave, say, Kentucky?

Ms. ARNETT. Because the regulations made the insurance so expensive that——

Mr. MCCRERY. But aren't they in the insurance business? What else are they going to do?

Ms. ARNETT. Go to another State.

Mr. MCCRERY. Ah, they can go to another State.

Ms. ARNETT. But, unfortunately, people can't, as you well point out.

Mr. MCCRERY. They can sell their products in other States, because those other States don't have similar regulations.

If we had a Federal regulation, though, that imposed nationwide, say, community ratings or guaranteed issue, would the effects be the same?

Ms. ARNETT. I would think so.

Mr. MCCRERY. You would think so?

Ms. ARNETT. I would expect so, because community ratings——

Mr. MCCRERY. You mean, there are not going to be any insurance companies left if we have a nationwide——

Ms. ARNETT. You would be moving toward a single payer system if you did that, ultimately, because the community rating is essen-

tially a form a price control. Price controls have not worked for 4,000 years.

Mr. MCCRERY. I don't think community rating is a price control. It is a price gathering mechanism, but it is not a price control.

Mr. SHEILS. I think——

Mr. MCCRERY. Mr. Sheils.

Mr. SHEILS [continuing]. I think questions of regulation are more complicated than that. If you have regulations that drive up the cost, then, basically, the insurance industry, we expect some part of it to survive, and they will sell insurance, but it will be very high rates, and it will be kind of a boutique business. There won't be as many people covered under it as you might have had historically. We did see a lot of commercial insurance companies leave the State of New York after some of their more recent regulations.

It is true that the grass is greener in other States where regulations concern, and firms will move. The thing about regulation in general is that all regulation probably generates some additional cost for consumers. You are forcing the insurers to do something they don't want to do. Why don't they want to do it? Because it is going to cost them money, and when that happens, your premiums go up.

Mr. MCCRERY. That is true with respect to most regulation, but I would submit that it is not true with community rating, because community rating is merely a method of assessing the cost of the group or the pool, and if you put everybody in the pool, as you do in community rating, then all insurance companies are on a level playingfield, if you have some risk adjustment mechanism that is there to compensate for one company getting more—a greater share of the bad risk.

Mr. SHEILS. Can I respond to that, though?

Mr. MCCRERY. Surely.

Mr. SHEILS. When you do community rating, one of the things that you are doing is leveling out the premium so that sicker people who were facing maybe $5,000 a year premiums, now they get it for $2,500. You are going to attract all those people into the market, but those people who are getting insurance for $100 a month—young people who are pretty healthy—those people are now going to be discouraged from buying insurance. So, you will change the composition of your insurance pool for sicker people, and that, in theory, can give you higher premium rates right there, which can lead to a loss of coverage.

Mr. MCCRERY. Surely. Absent a mandate, you would be absolutely correct.

Mr. SHEILS. Right, yes.

Mr. MCCRERY. I was getting to that, but my point is, it is not a cost to the insurance, though. The insurance company, their costs don't rise if you have community rating. Their costs rise if you mandate that they provide a certain type of health care coverage that they don't want to provide to everybody or they rise if you make insurance companies fill out all kinds of forms to prove that they are doing this, that, or the other, but they don't rise under community rating. They already have to rate—in fact, it might even reduce their costs, their administrative costs, if they don't

have to medically underwrite all of their policyholders. So, I was just making that point.

But you are right, if we don't make other reforms and if we don't mandate coverage, community rating would drive the cost up, because eventually you would have the health folks just saying, "Well, it is not worth it. I will just pay out of my pocket." That is not a bad idea. Maybe we should do that. [Laughter.]

Anyway, I will defer to my friend from Washington. Thank you all very much.

Chairman THOMAS. I thank the gentleman. Do you want to inquire again?

Mr. MCDERMOTT. Yes, as long as you will let us question these people and keep them from their lunch. Thank you.

We talk about regulation, and I guess I would like to hear your thinking about how it works, because I was in the State legislature when we put on two specific regulations from the State legislative level. One was the mandatory coverage of mental health care, and the second one was the mandatory coverage for breast reconstruction for those women who had had a breast removed due to cancer, and, clearly, that was done because—it wasn't because the legislature didn't have anything else to do on Wednesday. It was because there was public demand over this issue, so we responded to it.

Since I have been in Congress, we have gone through the same thing with HMOs where we have decided that a woman who has a baby should have the right to stay in a hospital overnight if she and her doctor think so, and so we passed a law here that said that. We regulated it from that level.

Is it your view that those regulations are best done up here as the public comes to us and demands that there be this change in coverage or is it better at the State level or is it just bad to do it at all? We should let the market take care of it totally and let people look at insurance policies and say, "Well, this covers breast reconstruction, and I might—" since, in women, that is that major form of cancer, the number one cancer—"that I might have one, so I ought to buy a policy that has reconstruction in it, right?" Is that the individual shopping that you are thinking about? Is that the best way to handle it; just leave the marketplace alone?

Mr. SHEILS. The problem with regulation, as I said earlier, is that it is going to involve additional cost. That doesn't mean it is a bad thing, and I really want to hit that. It doesn't mean it is a bad thing to do. We have regulations with automobiles. We can't even find a car without seatbelts in it. You have got to buy a car with seatbelts in it. We decided that is the way it is going to be done. The concern is that some of these regulations have the potential to really rob from the market lower cost alternatives to health insurance. Some of these provisions—and I think that Congress is actually not looking at anything that I would consider disastrously expensive at this point based on my read of what is around. There are some things that could be done which would be enormously expensive. Those things could generate a great deal of additional cost, and you would probably see a significant number of persons lose coverage.

There are other things that people are talking about doing there which cost one-tenth of 1 percent of premium and two-thousandths

of a premium here and there. Those things often involve things like information, making information available to people, having an appeals process, and so. Those things are things that are much less expensive and may actually be beneficial systemwide. But the concern that—since we are here to talk about the uninsured—the concern with regulation on what health plans should or shouldn't do always does carry with it the potential for some higher cost and the potential that that will result in some loss of coverage. We have to balance that. We have to say, "Well, everybody should have this basic protection with regard to breast reconstruction; everybody should have that, and that is all there is to it, and it is going to cost us more, but that is a choice that we may feel is appropriate. It is this whole business of trying to balance the two, and there is really no quantitative way of doing it. We can't say one is better than the other on the basis of some calculus you do somewhere.

Mr. MCDERMOTT. And our choice, then, is either to make those regulations ourselves as Congress people or let the market do it and see what happens.

Mr. SHEILS. Yes, I think Congress would have to do a lot of this, if you felt that there was something that had to be done in regulating, because States have no power over self-funded plans with ERISA and all. Since this is something we should have, Congress would have to do it, but not quite let the market do it so it would die, but there is this concern that if you regulate insurance into something that is substantially more costly to individuals, you are really robbing people of the opportunity to buy a lower cost health plan.

Mr. MCDERMOTT. My problem with this—we also went through the big health care reform proposal in the State of Washington, and we ran up against ERISA, and it seems to me, because of ERISA, you have to do it at the national level. I don't see how you can do otherwise. The insurance commissioner in the State of Washington covers about 40 percent of what goes on. The other 60 percent is behind the ERISA shield, and the insurance commissioner has absolutely nothing to say about it, and the legislature has nothing to say about it. So, it seems to me that all the regulation, ultimately, has to be done up here, as long as we allow ERISA to stand. Is that a fair estimate?

Mr. HOLAHAN. Yes.

Ms. ARNETT. The problem with that approach, though, Dr. McDermott, is the line really never ends of how many mandates the Congress would wind up having to put on, because whenever you are sick, what you need is what you need then. If there is not a mandate for that, people with similar problems will get together and ask Congress for it. With new technology, that line would continually grow longer, and I just don't see that there is ever an end to it.

Mr. HOLAHAN. There is a natural end to it, because it increases costs, which has consequence. It doesn't go on forever.

Mr. MCDERMOTT. Well, thank you. You have helped us a great deal to understand what we don't know.

Chairman THOMAS. One of the concerns, of course, that I have is, if we come back to reality, and we are looking at the uninsured unwilling to pay whatever the costs are, either mandated or be-

cause they have choices and that is simply not as high a priority as we might place on it that they choose not to, is to continue to support a tax structure which allows employers and employees to partially negotiate what would otherwise have been a wage for fringe benefits which are in essence free, and when a fringe benefit equals a wage in terms of its economic impact, you would get some discipline.

It just seems to me it would be a different world if we were willing to talk about a basic fundamental package that was covered with the tax provision, whatever it may be, and that all of those items that we think are desirable but not essential and especially effect only a portion of the population would be an aftertax add-on that would be available to individuals, that you have then at least a degree of self-regulation—choose it if you want to—but that we from a society are providing a basic package universally at a cost we can afford.

Of course, what you have to do is unravel U.S. history in health care areas since World War II and attempt to impose, for example, a cap on the tax credit. This Subcommittee, in the early eighties, attempted to do that and failed by two votes only of capping that credit, and I just am often amazed at how if the income tax structure was as disproportionately distributed as the health care tax credit is, some of our colleagues would be extremely upset of the regressive structure of that tax benefit. It, in fact, is true, and I would hope that they would be outraged by the regressive nature of the tax credit, but, unfortunately, there are some folks who are receiving a significant portion of that largesse who are in political alignment with some of those folks who would be upset if it were income, and that is why when you look for solutions that may in fact readily be arrived at from a structural point of view, the politics of it get very, very difficult.

And for those who remained, I am in awe of Mr. Stark who knows the solution and simply waiting for the markup to deliver it. Some of us think it is slightly more difficult than that, and I want to thank this panel for helping us continue to indicate that it isn't as simple as some folks may think it is.

The Subcommittee stands adjourned.

[Whereupon, at 1:22 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

THE COMMONWEALTH FUND
ONE EAST 75TH STREET
NEW YORK, NEW YORK 10021–2692
June 15, 1999

The Honorable Bill Thomas
Chair
Ways & Means Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Pete Stark
Ranking Member
Ways & Means Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Congressmen:

The Commonwealth Fund's *Task Force on the Future of Health Insurance for Working Americans* applauds you and the Subcommittee for holding today's hearing on Uninsured Americans. It is critical that the issue of health coverage for the uninsured is again brought to the attention of Congress and the American public. The Task Force looks forward to working with you and other members of the subcommittee as this issue moves ahead in the coming months and years.

The Task Force is a new national expert panel created by The Commonwealth Fund, a New York-based foundation. The Task Force will carry out and fund cutting-edge research on solutions to the problem of working Americans who lack health insurance coverage. The 15-member panel will be chaired by James J. Mongan, M.D., President of Massachusetts General Hospital.

The non-partisan expert task force—made up of individuals who are nationally recognized for their contributions to business, government, public policy, economics and/or medicine—will not advocate for specific solutions to the growing problem of working Americans who lack health care coverage. Instead, the panel will seek to accomplish the following two goals:

1) Put the debate over expanding health insurance coverage back on the national policy agenda, and

2) Make significant progress toward reducing the number of uninsured Americans and improving the quality of health insurance for working families.

The Task Force will provide constructive analyses on a wide range of incremental "workable solutions" that have the potential for broad-based, bipartisan political support. Panel members and staff will endeavor to assist public policy makers working on the issue of health coverage for working Americans through the dissemination of thoughtful, fact-based analysis of policy proposals and costs.

As you well know, federal legislative proposals to address problems with the employer-based health insurance system are needed, in part because:

- 43.1 million non-elderly Americans lacked health insurance in 1997
- 4 of 5 uninsured Americans in 1995 came from a family with at least one full time worker
- Working poor adults are twice as likely to be uninsured as are unemployed adults

To address the current problems with the job-based health insurance system, the Task Force will consider workable solutions including: refundable tax credits or other tax subsidies for the purchase of health coverage; expansion to working families of subsidized health coverage programs including Medicaid and the state Children's Health Insurance Program (CHIP); programs to allow the working uninsured to buy-in to existing state and federal employee health plans; and creation of a Medicare buy-in for older, uninsured workers. The Task Force will also be reviewing, performing and commissioning research on a variety of other workable solutions.

The Commonwealth Fund is a philanthropic foundation established in 1918 with the mission of enhancing the common good. The Fund currently carries out this charge through its efforts to help Americans live healthy and productive lives and to assist specific groups with serious and neglected problems. The Fund's four national program areas are improving health care services, bettering the health of minority Americans, advancing the well-being of elderly people, and developing the capacities of children and young people.

For more information please contact me, or John Budetti from the Task Force staff at (301) 913–0500. Or send information to 4800 Montgomery Lane, Suite 400, Bethesda, MD, 20814.

Sincerely,

JANET SHIKLES
Executive Director
Task Force on the Future of Health
Insurance for Working Americans

Statement of National Association of Health Underwriters, Arlington, Virginia

The Statement of National Association of Health Underwriters is an association of insurance professionals involved in the sale and service of health insurance, long-term care insurance, and related products, serving the insurance needs of over 100 million Americans. We have almost 16,000 members around the country. We appreciate this opportunity to present our comments regarding the rising number of uninsured Americans. NAHU has had a refundable Health Tax Credit proposal to address the problem of the uninsured for more than a decade, and is pleased to have this opportunity to present the key components of that proposal to the members of the subcommittee. The NAHU Health Credit will provide a real solution to the problem of the uninsured in America by addressing affordability—the most basic component of access to health care.

WHY DO WE NEED THE HEALTH CREDIT?

The current estimate on the number of uninsured in this country is more than 43 million people. That number represents an increase from a few years ago, despite numerous state and federal efforts to improve access. Over half of the 43 million uninsured Americans are the working poor or near poor, many of whom already have *access* to health insurance through an employer-based plan. Since employers already provide access to health plans and pay a significant portion of the premiums for many Americans, why do we have so many uninsured? The problem isn't access—it's affordability. They just can't pay for it.

This inability to pay has many causes. As we know, the United States government gives a tax break to people covered under their employer's health insurance plan. Health insurance premiums paid by an employer are not subject to income tax, even though many people consider employer-paid health insurance to be a part of compensation. Although this tax break has provided an excellent incentive for many people to become insured, it has also inadvertently created another problem—lack of tax equity. When an employer pays $100 in tax-free health insurance premiums for an employee in a 30% tax bracket, it's worth $30 to that employee. To another employee in a 15% tax bracket, it would be worth $15, and for the low-income employee with no tax liability or the person who is self-employed or otherwise has no employer-sponsored plan available, *the tax break is worth nothing.* Increased deductibility of health plan premiums for the self-employed has helped and will help more as deductibility levels are increased. But it does nothing for the bulk of the uninsured—the working poor with no or very low tax liability.

People with no tax liability don't benefit from a deduction for two reasons. First, if they owe no taxes, there is nothing to deduct the premiums from, even if the deduction were available without the requirement that a person itemize. Second, and probably more important for the working poor, *a deduction or even a credit which is only available at the end of the year might as well not be available at all, because if they can't get to it when their monthly premiums are due, they can't pay their premiums. That's why they are uninsured now.*

NAHU's tax credit is a refundable, advanceable credit, which means that people with no tax liability can get the credit monthly, when their premiums are due. This type of credit, advanced monthly and administered through the insurance company or the employer, would be simple to understand and almost impossible to abuse, since the insurance company or employer would certify that coverage was purchased. Such a credit would also enhance the effectiveness of COBRA's access mechanism by providing a means to pay COBRA premiums when people change jobs. Early retirees would be provided with the dollars that they needed to purchase a policy. And small employers who currently can't afford to provide a health insurance plan, would, with the combination of the contribution they are able to provide and

dollars provided to employees through the health credit, be able to offer a group health plan to workers.

Would the Health Credit disrupt the employer-based system? Absolutely not! We have specifically designed the Health Credit to be useable in an employer-based system. Most people are happy with the employer-based system, according to a recent survey by the Employee Benefits Research Institute. By allowing a credit to be available to all Americans, including those who obtain their health insurance through the employer-based system, we allow families to be insured together, which many employees prefer. Since most employers do not contribute towards dependent health insurance premiums, a credit which is not available through a plan where an employer pays part of the premiums would not satisfy the desire of most employees to have their entire family insured under one plan. Those who will benefit the most are the lower income employees, the working poor and "near-poor" whose employers at best pay a portion of the employee premium and none of the dependent premium—people who cannot now afford to come up with "their share" of health insurance premiums.

NAHU spent a considerable amount of time selecting the dollar amount of the credit, taking great care to make the credit low enough so that it would not provide an incentive for employers to discontinue their financial contributions toward plans, and high enough to provide a meaningful incentive for people without access to an employer-sponsored plan. The amount of the credit is simply not large enough to cause an employer to stop providing coverage for employees. In addition, if an employee wants to use the credit "outside" of his or her employer's plan, *they also leave behind the employer's financial contribution towards coverage.* Very few employees would choose to use their credit on its own in the individual market when they could easily combine it with an employer's contribution to purchase in their employer's plan.

With the recent decline in employer-provided health insurance along with the increase in group rates resulting from guaranteed issue, the number of uninsured is likely to increase further. Many other people have only minimal health insurance coverage. The lack of insurance not only limits the availability of health care to these people, but also, when pro-bono medical care is provided, results in a cost shift that raises insurance premiums for everybody else. The problem of the uninsured thus remains a major national problem that must be addressed.

NAHU believes that all Americans should have access to affordable health insurance, and offers the Health Credit as an activist, innovative way to achieve insurance coverage through the competitive private sector.

WHAT THE NAHU HEALTH CREDIT ACCOMPLISHES

- The Health Credit will ensure that all Americans, regardless of income, have a basic level of resources to purchase health insurance.
- It creates a fair system that will enable everyone to obtain insurance protection, thus in essence achieving universal coverage, but through incentives rather than mandates.
- It focuses on achieving insurance security through the private, free enterprise system rather than through government programs.
- It retains the employer-based system of health insurance, including the ability to treat employer paid premiums as tax deductible business expenses, but for the first time equalizes the tax breaks for those who must out of necessity obtain insurance outside the employer-based system.
- If employers do not provide health insurance, the employees will be able to use the tax credit to help finance insurance coverage. Where employers provide only a fraction of the cost, employees can use the credit to help pay their share of the premium.
- The unemployed will have the credit available to help with the cost of insurance between jobs.
- Early retirees will be able to use the credit until they are eligible for Medicare.
- Self-employed individuals may elect to maintain their current tax treatment of health insurance premiums whereby premiums are deductible as a business expense and not reportable as personal income, or, they may elect to receive the Health Credit. If they opt for the Health Credit, they will receive the same business deduction for health plan premiums as under the current system. They will report the entire premium as unearned income on their personal return but no self-employment tax will be paid on the health plan premium. Accordingly, self-employed individuals will be treated exactly like corporate employees.

• The same credit will be available regardless of whether a person is employed or unemployed, thus encouraging movement into the work force and removing the present incentive to stay on welfare in order to avoid losing Medicaid.
• The Health Credit, by being available only for the purchase of private sector insurance, will allow a shift of low-income individuals from the very costly Medicaid program into private insurance plans.

ELIGIBLE POPULATION

All American citizens would be eligible for the Health Credit except those in the Medicare program and participants in the military health plan, both of which have unique characteristics. There could conceivably be ways to apply the Credit to these groups, and NAHU would not be opposed to that if effective, financially supported, ways are found. NAHU believes that the Credit should not go to non-citizens because of their questionable tax status and the complexity of administering the Credit in such cases.

SIZE OF THE HEALTH CREDIT

The amount of the Credit will be $800 per adult and $400 per child (under 18) to annual maximum of $2,400 per family. A two-parent family of four would therefore receive a total credit of $2400 annually. The Credit is a flat credit that will be the same for all eligible persons, regardless of income.

The amount of the Credit will periodically change to reflect increases or decreases in the cost of living, as reflected by the medical Consumer Price Index (CPI). Changes will occur in $50 increments, in order to insure simplicity. Consequently, the Credit will be adjusted only when cumulative yearly CPI percentage changes exceed the level necessary to produce the $50 change.

FINANCING THE COST OF THE HEALTH CREDIT

The primary source of funding results from a change in the tax law providing that the employer share of health insurance premiums (or the COBRA cost equivalent in the case of self-insured companies) will be considered as unearned income to the employee, thus subject to income taxation. The Health Credit will in most cases, however, offset whatever the employee pays in the way of extra income taxes, as well as part or most of the cost, depending on the amount, of any premiums paid by the employee.

Because the vast majority of people will gain rather than lose under the Credit, the revenue loss to the federal government from the Credit is substantially more than the additional revenue resulting from the increase in taxable income. Other funding for the Credit comes from expense reductions in the cost of coverage for Medicaid recipients who move from Medicaid and the Children's Health Insurance Program to the private sector, as well as a reduction in provider tax deductions for uncompensated care.

ADMINISTERING THE HEALTH CREDIT

One of the major advantages of the Health Credit is that it is a flat credit, the same for everybody, and therefore easy to administer. No bureaucratic calculations will be needed to determine the amount of the Credit based on a person's income level, percentage of poverty, changing economic circumstances, etc. It is one size fits all, with virtually everybody being eligible. The result is not only less administrative cost, but also less likelihood of fraud resulting from people trying to "game" the system. There is nothing to "game."

With regard to the payment of the Health Credit, the Department of the Treasury will have primary responsibility for overall administration. The Credit, while owned by the individual, will not be paid directly to the individual, but will be transmitted to an insurance company, employer, or other organization maintaining the individual's insurance account. The Credit may be used only for the payment of private insurance premiums, and may not exceed the total cost of the premiums. The Credit may also be deposited in a third-party administered medical savings account that includes catastrophic insurance coverage. Only health plans eligible as creditable coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) will be eligible for Credit payment.

The Treasury will maintain a computerized record of the amount of eligible Credit for each individual, or family, updated on a monthly basis. The Credit will be determined on a monthly prorated basis, in order to ensure the continuing availability

of Credit funds throughout the year, particularly in cases of job change, and to help protect against fraud.

In cases of employer-provided insurance, the Health Credit allocation can be handled as part of the regular withholding process. The Credit would be shown as a specific line item on the pay stub. Federal income taxes withheld by the employer on behalf of employees would be reduced by the amount of the Credit before being sent to the government. The employer's share of the insurance premium would be considered as additional unearned income to the employee, on which income taxes (but not social security taxes) would be paid. The employer would withhold these taxes at the regular marginal withholding rate for that employee.

How the Health Credit Works

If a health insurance policy provided by the employer has a total monthly premium of $400, with the employer paying 50% ($200) and the employee 50% ($200), the employee would, under the Health Credit plan, pay a federal income tax on the $200 employer share of the premium which, as unearned income, in the 15% tax bracket, would amount to $30 a month. If the employee has a family of four, the monthly Health Credit of $200 ($2400 annually) would fully cover the increased taxes, and most of the balance of the insurance premium.

The net effect would be that the employee in this example, instead of paying a $200 monthly premium, would in essence pay only a $30 premium under the Health Credit plan. If the employee is in the 28% marginal tax bracket, the extra monthly tax would be $56, leaving $144 under the Credit, after payment of the tax, to go toward the employee's insurance premium. Even in the top 39% bracket, with an increased tax of $78, this employee would come out ahead.

In another example, if the employer pays no portion of health insurance premiums, the employee would have available the entire $200 credit per month to offset what he or she has to pay for insurance elsewhere.

If the employee or anyone else does not choose to purchase insurance, they would not receive the Credit. The amount of the credit if insurance is purchased is the lesser of the premium paid or the maximum eligible credit. There is a strong incentive, in other words, to purchase insurance and in an amount at least up to the level of the Credit. Most people would not want to give up something from the government without getting anything in return.

Impact of the Health Credit on the Individual

The Health Credit is a fair credit in that it is the same for everybody. Everyone is treated equally. At the same time, those in low-income categories receive a greater proportional benefit than those in high-income categories. A $2400 Credit for a family earning $15,000 represents a 16% increase in income, whereas such a Credit for a family in the $100,000 income category is just a 2.4% increase. Likewise, if in these two cases both families receive the same insurance policy 100% paid for by the employer, in the first case the tax for the family on the employer-paid premium would likely be zero or 15% at the most, while the tax for the latter family would be at least 28%. In most income categories, people will come out ahead under the Health Credit compared to where they are today.

At the end of the year, if an individual determines that s/he would have been better off under the current tax exemption system, s/he may amend his or her tax return and take the value of the current exemption instead of the Health Credit. Those who have a Section 125 Plan through their employer can still take advantage of their employer's Section 125 Plan for FICA savings and for other, non-health insurance premiums and benefits.

Impact of the Health Credit on the Employer

Under the Health Credit, the employer would retain the business tax deduction for whatever the employer provides in the way of health insurance or other health care coverage. Furthermore, employer-paid premiums that will be treated as unearned, taxable income for the employee will not be subject to the FICA tax for the employee or employer, nor will they be treated as additional payroll income and thus subject to various state payroll taxes, such as unemployment, workers' compensation, etc. So the firm will have the same incentive it has now to finance the cost of insurance.

HEALTH ECONOMIC IMPACT OF THE HEALTH CREDIT

A tax credit for the purchase of insurance will make it possible for many more people to obtain insurance. By doing so, it would help to lower the per capita cost of insurance. It would do so in two ways: by reducing the amount of uncompensated care that is offset through cost shifting to private sector insurance plans, and by substantially increasing the insurance base, spreading the cost over a wider number of people. The credit will also encourage insurance companies to write policies more geared to the size of the credit, thus offering more options and making it possible for low income families to obtain coverage without paying much more than the credits available.

SUMMARY

NAHU's Health Credit represents a simple and realistic way to extend private health insurance coverage to the uninsured and underinsured. It will help many other Americans with the cost of their existing insurance coverage. Unlike some tax credit proposals, the NAHU credit strengthens the employer-based health insurance system. It is fair and is easy to administer. It is a private sector solution to a difficult problem. It gives people the tools to make their own decisions.

With all the talk today of Patient Protections, we seem to have forgotten the most important protection of all—the ability to afford coverage. Access and choice can't exist without the dollars required to buy a health plan. It's time now for Congress to step up to the plate and reshape the current tax system to benefit all Americans in the form of real access to health care —the dollars to pay for it.

Statement of Private Citizen, St. Louis, Missouri

The passage of the Health Insurance Portability and Accountability Act is a commendable step in improving access to health insurance and reducing job lock. While improving access to insurance, it does nothing to ensure affordable rates, if an individual must switch to individual insurance, after having developed a health condition under an individual plan. Further reform is needed to ensure that responsible citizens who carry health insurance will be able to retain affordable coverage over the long term if they should become ill.

This proposal is divided into the following sections:

Problems with the Current System of Health Insurance
The Core Reform Proposal
Cost Issues Related to the Core Proposal
Other Comments about the Core Proposal
Additional Reforms Needed
Cost Issues Related to the Additional Reforms

Problems with the Current System of Health Insurance:

PORTABILITY PROBLEMS

—The Health Insurance Portability and Accountability Act (HIPAA) does nothing to ensure affordable rates, if an individual must switch to individual insurance, after having developed a health condition. Individuals may be exposed to extremely high premiums.

OTHER PROBLEMS CONCERNING INDIVIDUAL INSURANCE

—If an individual becomes ill under an individual policy, their rates can be raised or their policy canceled.

—Insurance companies should not be allowed to move individual policy holders from one internal risk group to another so that they can increase individual premiums on some groups of their policy holders due to claims. I have heard from some insurance agents that this practice may occur under some policies without the knowledge of policy holders.

—When one insurance company takes over another insurance company, the individual policy holders need to be protected from behind the scenes risk class manipulations, and other detrimental changes to their policy.

—Insurance companies have sometimes deliberately failed to send a renewal notice to sick policy holders, hoping they would forget to renew their policy.

—There should be a guarantee that parents can obtain insurance for a child born with health problems or birth defects. Or at least, considering the principle that one

ordinarily buys insurance prior to the risk, parents should be about to buy the insurance for the child during pregnancy without health considerations.

PROBLEMS CONCERNING GROUP INSURANCE

—HIPAA provides protections for employer group policies and not other types of groups, such as alumni associations, professional and trade organizations, etc.

—HIPAA does not prevent an insurer from raising the premium on a group due to claims from its members.

—When an employer self-insures health of its employees, the employer should be subject to any regulations that would effect insurance companies offering a similar policy, including any applicable consumer protections and liability, if the plan is of HMO style. The ERISA provisions that release employers and their HMO's from liability can harm the employee.

PROBLEMS CONCERNING LEAVING AN EMPLOYER GROUP

—The current guaranteed ability for employees to convert their existing group policy to an individual policy on leaving the company is often too expensive, and sometimes reduces the coverages, if the original policy had riders for some of its coverages.

—A group policy may not always continue its riders when used under COBRA. Riders such as prescription drug coverage should continue.

—COBRA places a responsibility on the employer to continue insurance, but the insurance company is not required to carry COBRA customers, sometimes leaving an employer to his own devices to determine how to provide the ex-employee with insurance. If the employer cannot meet the responsibility, the ex-employee patient may be unable to use HIPAA to get an individual policy because he did not do COBRA first. This places both the employer and patient in an unfair bind.

Insurance companies have delayed the application process of HIPAA applicants to cause them to run out their 63 day eligibility period, in order to avoid covering them.

OTHER PROBLEMS

—Coverage disputes with HMO's need to involve an independent third party in the appeals hearing.

—The problems regarding health insurance stem partly from the federal income tax code, which encouraged the practice of associating health insurance with employment. The tax code is inconsistent in that employer health insurance is tax free, while individuals who buy their own insurance pay taxes on income used for this purpose, except if they are self employed, then there is partial tax deductibility.

—Many insurance companies and agents refuse to send a sample insurance policy. This makes shopping for all types of insurance more difficult.

The Core Reform Proposal:

The following provisions would solve what I believe are some of the worst problems of the health insurance system:

—To make health insurance more portable (e.g. to better allow transitions to situations of self employment, jobs that don't offer health insurance, or leaving the workforce), a person who developed a condition while under a health insurance policy (group or individual) would be able to move to a new individual policy and pay the same rate and be underwritten in the same class or group of policies as a healthy person of the same age, sex, and smoking status, in addition to avoiding the delay for coverage of pre-existing condition.

—A person would retain this protection through multiple policy changes over a lifetime, as the insurance industry offerings evolve. This protection is important if a person has individual insurance and loses it or becomes dissatisfied because the insurance company ceases service in the area, goes bankrupt, discontinues or changes the product an unsatisfactory manner, is merged or taken over by another insurance company, or the individual cannot afford the premium and needs a lower cost plan whether offered by the original insurer or a competitor.

—These protections would apply whenever an individual does not have a break in coverage longer than 63 days since their prior period of insurance coverage. To prevent this time limit from being wasted by stonewalling insurance companies, the 63 days should be counted backward from the date of application for new insurance, and insurance companies must process applications in a timely manner.

—These insurance protections should apply to allow insured young adults to transfer from a parent's health insurance plan to their own insurance, regardless

of health and for Senior Citizens to transfer between Medicare Supplement policies and HMO's and vice versa.

—For those who have had a gap exceeding 63 days, insurance companies would be free to use a separate risk group and higher prices, based on health history, in order to protect the system from people who wait until they are sick to purchase insurance.

—The use of standard risk class for these insurance transfers may imply some minimal protection, even if the law to allow them is later repealed, as any individual policy obtained by these guidelines would be an ordinary individual policy, rather than a separate product or risk class, as now created by HIPAA, which could be priced or discontinued separately.

—Insurance companies would not be allowed to move individual policy holders from one risk group to another so that they can increase individual premiums on some persons. Individual premiums should be based solely on age, sex, smoking status, geographic location (a broad-brush division of the state into several areas), and health history (only if individual has had a gap in coverage of 63 days or longer immediately prior to the application date). Individual experience rating should be prohibited, to prevent rate increases resulting from a decline of health during coverage.

—The guaranteed acceptance into a group policy for a new employer would be extended to all groups that a person is a member of for which health insurance is sold (Alumni associations, professional and trade organizations, etc.). For example, if an Alumni association offers group health insurance to graduates of a particular school or university, it would have to take all graduates of that school and not impose delays or higher premiums for pre-existing conditions (subject to the 63 day gap rule).

—Insurance companies would not be allowed to raise the premium on a group policy due to change in health of existing members.

Cost Issues Related to the Core Proposal:

—The approach of providing total portability only when an individual has prior coverage is superior to a simple total ban on health history questions and pre-existing condition considerations, as it requires a person to have had insurance to receive the protections, thus protecting the system against abuse by people waiting to get insurance until they are sick.

—Imposing this protection only in cases where the person had prior coverage should minimize any resulting increase in the cost of individual health insurance, as the total cost borne by the industry in claims should not be strongly impacted if a chronically ill person moves from one policy to another, as that person would not move now if he could not get satisfactory coverage. (It may be necessary to require that the policies be similar, to prevent a dramatic, abusive upgrade in coverage at standard prices after a person becomes ill. It would also be necessary to allow transfer to a slightly better policy sometimes, to prevent a long term erosion toward inferior coverage for people who become chronically ill for decades and go through several insurers.)

—A reinsurance pool could be used by insurance companies to protect themselves from the risk of a disproportionate number of transfers of sick persons to their policies, but this pool should be invisible to the consumer.

—Due to the provision against raising group premiums, there may be some small increases in the cost of group insurance for the more healthy groups that would take place instead of sharp increases in the cost of group insurance for groups that have one or more unhealthy members. This is a good thing, as it make insurance do what it was intended to do—spread the risk.

—The Core Proposal will require no public funds other than those used to monitor insurance companies and enforce the rules.

Other Comments about the Core Proposal:

—These protections would help responsible self employed and small business owners/employees who have maintained health insurance, as they could obtain individual insurance at an affordable price.

—The COBRA problems would disappear, as COBRA would fall into disuse due to the new better options.

Additional Reforms Needed:

The following provisions would make a more complete reform, but are outside what I consider to the be core proposal:

—For the poor, Medicaid should be considered a qualifying insurance for purposes of allowing purchase an individual policy when a period of poverty ends.

—There should be a guarantee that parents can obtain insurance for a child born with health problems or birth defects. Or at least, considering the principle that one ordinarily buys insurance prior to the risk, parents should be about to buy the insurance for the child during pregnancy without health considerations.

—One should be able to purchase health insurance in a standard risk class upon reaching adulthood, regardless of whether the parents maintained insurance during childhood, e.g. to not hold the young adult responsible for mistakes of his or her parents.

—Many insurance companies and agents refuse to send a sample insurance policy. The text of all insurance policies of all types should be a part of the public record to aid shoppers for insurance. The text of policies can be shown on the World Wide Web (WWW) at minimal cost to the public and/or insurance companies may be required to make the sample policies available at their cost.

—The inconsistent tax treatment of health insurance premiums should be corrected to reduce this unfairness in the tax code. Regulations regarding the deductibility of health insurance premiums should not vary depending on whether premiums are paid by employer, employee, self-employed individual, or non worker. But it would be dangerous to implement the tax change without the other reforms, as some employers would drop insurance, and many sick people would then have inadequate protection.

—Lifetime policy dollar limits should be prohibited, or at least required to be indexed for inflation using a health care index, or perhaps insurance companies should provide a choice of several indexed dollar limits, much as a policy buyer chooses a deductible. Perhaps a minimum dollar limit should be considered.

—When an employer self-insures health of its employees, the employer should be subject to any regulations that would effect insurance companies offering a similar policy, including applicable HMO consumer protections, if the plan is of HMO style.

—When one insurance company takes over another insurance company, policyholders of the old company should have the option of keeping the original terms of their policy.

—Insurance companies should be required to send bills and renewal notices to all policy holders in a timely manner. They should provide the option to the policy holder to have their bills sent by certified mail return receipt requested for an extra billing fee equal to the additional postage. If a policy holder chooses this option, then the insurance company shall be forbidden to cancel the policy for nonpayment of premium for at least 30 days after the day the bill is sent, or 30 days after the renewal date, whichever is later, and then only if they have the card back that the bill was received. This provides the customer the option to make it the insurance company's legal obligation to remind them of their premiums via a bill and to ensure that the bill must be received. If certified mail billing is not chosen, cancellation should not occur before 30 days after the renewal date.

Cost Issues Related to the Additional Reforms:

—The provisions for children and transition to adulthood may require public funds or the cost may be spread out in higher premiums for everyone or higher premiums for child and young adult policies.

—If sample policies are to be shown on a government operated web site, there would be some costs for web development services to create and maintain the site.

—The tax provision may have a cost, or may raise revenue, depending on whether all premiums are made deductible, partially deductible, or taxable.